State of Illinois
Department of Central Management Services
Bureau of Benefits

College Insurance Program

Benefits Handbook

July 1, 2015 *(Originally Published October 2011)*

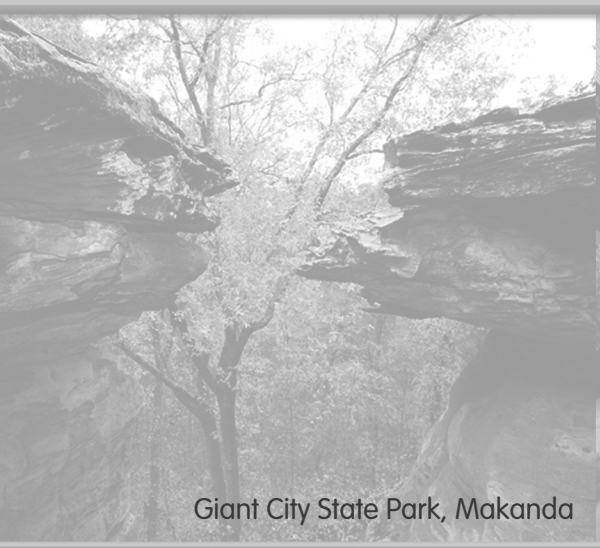
Illinois State Capitol, Springfield

Chicago Theatre, Chicago

Chicago Skyline, Chicago

College Insurance Program

Benefits Handbook



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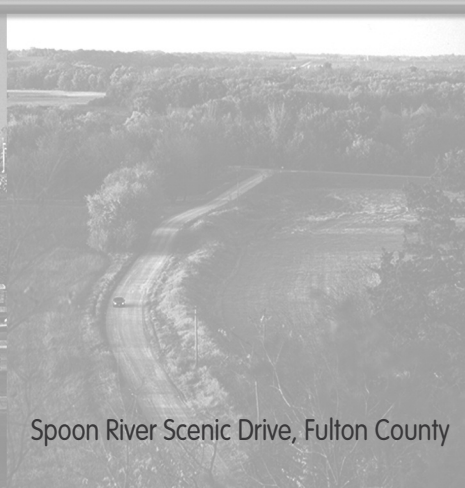

Spoon River Scenic Drive, Fulton County

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Introduction

Your Group Insurance Benefits

Please read this handbook carefully as it contains vital information about your benefits.

The Bureau of Benefits within the Department of Central Management Services (Department) is the bureau that administers the College Insurance Program (CIP) as set forth in the State Employees Group Insurance Act of 1971 (Act). You have the opportunity to review your choices and change your coverage for each plan year during the annual Benefit Choice Period. If a qualifying change in status occurs, you may be allowed to make a change to your coverage that is consistent with the qualifying event. See the section 'Enrollment Periods' for more information.

Where To Get Additional Information

If you have questions after reviewing this book, please refer to the following:

- The Department's website contains the most up-to-date information regarding benefits and links to plan administrators' websites. Visit **www.benefitschoice.il.gov** for information.
- Annual Benefit Choice Options booklet. This booklet contains the most current information regarding changes for the plan year. New benefits, changes in premium amounts and changes in plan administrators are included in the booklet. **Review this booklet carefully as it contains important eligibility and benefit information that may affect your coverage**. Visit **www.benefitschoice.il.gov** to view the booklet.
- SURS is a valuable resource for answering questions you may have about your eligibility for coverage and to assist you in enrolling or changing the benefits you have selected. SURS can be reached at:

  State Universities Retirement System
  1901 Fox Drive
  P.O. Box 2710
  Champaign, IL 61825-2710
  (800) 275-7877
  TDD/TTY: (800) 526-0844
  www.surs.org

- The Department can answer your benefit questions or refer you to the appropriate resource for assistance. The Group Insurance Division can be reached at:

  DCMS Group Insurance Division
  801 S. 7th Street
  P.O. Box 19208
  Springfield, IL 62794-9208
  (800) 442-1300 or (217) 782-2548
  TDD/TTY: (800) 526-0844

- Each individual plan administrator can provide you with specific information regarding plan coverage inclusions/exclusions.

ID Cards

The plan administrators produce ID cards at the time of enrollment. Cards are mailed to the current address on file with the Bureau of Benefits. To obtain additional cards, contact the plan administrator. Links to the plan administrators' websites can be found at **www.benefitschoice.il.gov**.

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

The State contracts with business associates (health plan administrators and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavioral health services and prescription drug benefits.

If you are enrolled in CIP, a copy of the Notice of Privacy Practices will be sent to you on an annual basis. Additional copies are available on the Benefits website.

Your Responsibilities

It is your responsibility to know your benefits, including coverage limitations and exclusions, and to review the information in this publication. Referral and/or approval for treatment by a physician does not ensure coverage under the plan.

You must notify SURS immediately when any of the following occurs:

- **You and/or your dependents experience a change of address.** When you and/or your dependents move, you must provide written notification to SURS. Changing your address with the retirement system does not automatically change your health plan to a plan in that geographic area. If you move out of the managed care service area, a written request to elect a new health plan is required. If you are currently enrolled in an HMO and you move to a county that does not offer that HMO plan, you have 30 days from the date of your move to change health plans. Refer to the managed care coverage map in the Benefit Choice Options booklet for health plan options available in your county.
- **Your dependent loses eligibility.** Dependents that are no longer eligible under CIP (including divorced spouses or partners of a dissolved civil union partnership) must be reported to SURS immediately in writing. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You get married or enter into a civil union, or your marriage or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **Your dependent's employment status changes.**
- **Your dependent dies.**
- **You have or gain other coverage.** If you have group coverage provided by a plan other than CIP, or if you or your dependents gain other coverage during the plan year, you must provide that information to SURS **immediately**.

Contact SURS if you are uncertain whether or not a life-changing event needs to be reported.

If you and/or your dependent experience a change in Medicare status or become eligible for Medicare benefits, a copy of the Medicare card must be provided to the State of Illinois Medicare Coordination of Benefits (COB) Unit. Failure to notify the Medicare COB Unit of you and/or your dependent's Medicare eligibility may result in substantial financial liabilities. Refer to the 'Medicare Section' for the Medicare COB Unit's contact information.

Benefit recipients should periodically review the following to ensure all benefit information is accurate:

- **Insurance Deductions.** It is your responsibility to ensure deductions are accurate for the insurance coverage you have selected/enrolled. If your annuity check is insufficient to cover your premiums, you will be billed for the cost of your current coverage. **Failure to pay the bill may result in a loss of coverage and/or withholding through the SURS annuity check.**

If You Live or Spend Time Outside Illinois

Benefit recipients who move out of Illinois or the country will most likely need to enroll in the College Choice Health Plan (CCHP). For those in certain areas contiguous to the State of Illinois, some managed care health plan options may be available. Refer to the current Benefit Choice Options booklet or contact the managed care health plan directly for information on plans available. Changing your address does not automatically change your health plan.

Dependents Who Live Apart from the Benefit Recipient

Eligible dependents who are enrolled in an HMO plan and live apart from the benefit recipient's residence and are out of the plan's service area for any part of a plan year will be limited to coverage for emergency services only. It is crucial that benefit recipients who have an out-of-area dependent (such as a college student) contact the HMO plan to understand the plan's guidelines on this type of coverage.

Your Responsibilities (cont.)

Power of Attorney

Benefit recipients may want to consider having a financial power of attorney on file with both the retirement system and the health plan to allow a representative to act on their behalf. For purposes of group insurance, a financial or property power of attorney is necessary; a healthcare power of attorney does not permit changes to health insurance coverage.

Penalty for Fraud

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under CIP is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the benefit recipient and/or the dependent beneficiary, as well as expenses incurred by CIP.

Chapter 1

Chapter 1: Enrollment and Eligibility Information

Eligibility Requirements

This section contains benefit eligibility information which applies to all CIP health, dental and vision plans.

Eligibility Requirements

Eligibility is defined by the State Employees Group Insurance Act of 1971 (5 ILCS 375/1 et seq.) or as hereafter amended (Act), and by such policies, rules and regulations as shall be promulgated there under. If there is any change in eligibility (qualifying change in status, Medicare eligibility, residential address) notify SURS immediately at (800) 275-7877. Failure to notify SURS of eligibility changes may result in loss of benefits and/or premiums.

Eligible as Benefit Recipient

To be eligible, benefit recipients must be receiving a monthly retirement or survivor annuity benefit from SURS under Article 15 (SURS) of the Illinois Pension Code; and either (I) have been a full-time employee of a community college district or an association of community college boards created under the Public Community College Act and was eligible to participate in a group health benefit plan as an employee during the time of employment with a community college district or an association of community college boards; or (II) be a survivor of an eligible CIP member.

Benefit recipients enrolled in any of the CIP health plans are not eligible for health, dental or vision coverage as a member under the State Employees Group Insurance Program.

Eligible as Dependents

Eligible dependent beneficiaries of a benefit recipient may participate in CIP. Dependent coverage is an additional cost for all members.

Eligible dependents include the benefit recipient's:

- **Spouse** (does not include ex-spouses, common-law spouses, persons not legally married or the new spouse of a survivor).
- **Civil Union Partner (enrolled on or after June 1, 2011).**
- **Parent.** Parent must be dependent upon the benefit recipient for more than one-half of their support and eligible to be claimed by the benefit recipient as a dependent for income tax purposes.
- **Child from birth to age 26, including:**
  - Natural child.
  - Adopted child.
  - Stepchild or child of a civil union partner.
  - Child for whom the benefit recipient has permanent legal guardianship.
  - Adjudicated child for whom a U.S. court decree has established a member's financial responsibility for the child's medical, dental or other healthcare.
- **Child age 26 and older, including:**
  - Adult Veteran Child. Unmarried adult child age 26 up to, but not including, age 30, an Illinois resident, has served as a member of the active or reserve components of any of the branches of the U.S. Armed Forces and received a release or discharge other than a dishonorable discharge.
  - Disabled. Child age 26 or older who is continuously disabled from a cause originating prior to age 26. In addition, for tax years in which the child is age 27 or above, eligible to be claimed as a dependent for income tax purposes by the benefit recipient.

NOTE: Survivors may add a dependent only if that dependent was eligible for coverage as a dependent under the original member.

Eligibility Requirements (cont.)

Certification of Dependent Coverage

In addition to the following certification periods, SURS may ask the employee to certify their dependent either randomly or during an audit anytime during the year.

Birth Date Certification. Benefit recipients must verify continued eligibility for dependents turning ages 26 and 30. Members with dependents turning ages 26 and 30 will receive a letter from SURS several weeks prior to the birth month that contains information regarding continuation of coverage requirements and options. The member must provide the required documentation to SURS prior to the dependent's birth date. Failure to certify the dependent's eligibility will result in the dependent's coverage being terminated effective the end of the birth month.

Annual Certification. Benefit recipients are required to certify all IRS dependents in the following categories on an annual basis: Parent, Disabled and Adult Veteran Child (age 26 and older).

Reinstatement of Dependent Coverage. If coverage for a dependent is terminated for failure to certify and the member provides the required documentation within 30 days from the date the termination was processed, coverage will be reinstated retroactive to the date of termination.

After 30 days the coverage will be reinstated only with a qualifying change in status (see qualifying change in status reasons in the 'Enrollment Periods' section later in this chapter). **Termination of coverage for failure to certify is not a qualifying change in status.**

Contact SURS for questions regarding certification of a dependent.

Enrollment Periods

Benefit recipients have several opportunities to initially enroll in CIP. After the initial enrollment, if the benefit recipient terminates CIP coverage, re-enrollment opportunities are limited.

Initial Enrollment

Benefit recipients may enroll in CIP during the annual Benefit Choice Period **only** if they have never previously been enrolled in CIP. Benefit recipients who are eligible for, but have never enrolled in, one of the health plans under CIP may do so during the annual Benefit Choice Period. The coverage becomes effective July 1st. Preexisting condition limitations do not apply to coverage under the CIP plan.

Outside the annual Benefit Choice Period, benefit recipients may enroll in CIP when one of the following occurs, regardless of whether or not they have ever been previously enrolled in the program:

- **Upon application of annuity benefits.** An enrollment application must be submitted to SURS no later than 30 days after the effective date of the pension benefits. Coverage will be effective the first day of the first full month of benefits or the first day of the month that the enrollment application is received, whichever is later. The effective date may be delayed up to 4 months after the effective date of the pension benefits; however, SURS must receive the enrollment form within 30 days of the effective date of the pension benefits.
- **The benefit recipient becomes eligible for Medicare**. Benefit recipients who become eligible for Medicare may apply for coverage. Benefit recipients must apply within 6 months from the date they became Medicare eligible. If the benefit recipient is Medicare eligible due to turning 65, and they wish to enroll in CIP, they should contact SURS prior to their 65th birthday. Coverage will be effective the first day of the month in which the benefit recipient becomes Medicare eligible or the first day of the month when the enrollment application is received by SURS, whichever is later.
- **The benefit recipient has been determined to be ineligible for Medicare.** Benefit recipients who are Medicare ineligible have 30 days from their 65th birthday to apply for coverage. Coverage will be effective the first day of the month in which the benefit recipient reaches age 65 or the first day of the month when the enrollment application is received by SURS, whichever is later.
- **Coverage is terminated by a former group plan.** Benefit recipients who are eligible to enroll in CIP but instead continue coverage with another plan, may enroll if the other plan terminates coverage. The benefit recipient has 30 days following the loss of other coverage to submit the enrollment application to SURS, along with a letter from the former plan stating the effective date of termination. Termination of coverage must be initiated by the former group plan. Termination for nonpayment of premium does not qualify as loss of coverage by the group plan and therefore is not an eligible enrollment event. The effective date of the coverage is the first day of the month following cancellation of coverage with the other plan.

Annual Benefit Choice Period

The Benefit Choice Period is normally held annually May 1st through May 31st. During this 31-day period, benefit recipients may change their health and dependent coverage elections. Coverage elected during the annual Benefit Choice Period remains in effect throughout the entire plan year unless the member experiences a qualifying change in status or the Department institutes a special enrollment period which would allow the member to change their coverage elections.

Benefit recipients may make the following elections during the annual Benefit Choice Period:

- Enroll in the College Insurance Program – applies to benefit recipients and dependent beneficiaries who have never been previously enrolled in CIP.
- Change health plans.
- Add eligible dependents. Social security numbers are required to add dependent coverage. Refer to the 'Dependent Coverage' section for documentation requirements.

Effective Date of Coverage Due to the Annual Benefit Choice Period:

All Benefit Choice health and dependent coverage changes become effective July 1st.

Enrollment Periods (cont.)

Qualifying Change in Status

The Department's administrative policy prohibits changes in the benefit recipient's elections during the plan year unless there is a qualifying change in status. Any request to change an election mid-year must be consistent with the qualifying event the benefit recipient or dependent has experienced.

Qualifying change in status events include, but are not limited to:

- Events that change a benefit recipient's legal relationship status, including marriage, civil union partnership, death of spouse or civil union partner, divorce, legal separation, civil union dissolution or annulment.
- Events that change a benefit recipient's number of dependents, including birth, death, adoption or placement for adoption.
- Events that cause a dependent to satisfy or cease to satisfy eligibility requirements for coverage.
- A change of permanent residential county for the benefit recipient or their dependent or, a move to a foreign county by an eligible dependent.

Benefit recipients experiencing a qualifying change in status have 30 days to request a change to their benefit selection. Members must submit proper supporting documentation to SURS within 30 days in order for the change to become effective (31 days for a birth or adoption).

Effective Date of Coverage Due to a Qualifying Change in Status:

Coverage election changes made due to a qualifying event are effective the first day of the month following the date of the event as long as the request is made within the required time frame.

Qualifying Change in Status Effective Date Exceptions:

- **Newborns, natural or adopted**. A child is considered a newborn if they are within 31 days of birth. If the request to add the child is made within 31 days of the birth, coverage may be retroactive to the date of birth.
- **Adopted children, other than newborn**. Requests to add an adopted child who is 31 days old or older will be effective the date of the placement of the child, the filing of the adoption petition or the entry of the adoption order provided that the request is received within 31 days of the placement of the child, filing of the adoption petition or the entry of the adoption order.

Dependent Coverage

Enrolling Dependents

Dependent beneficiaries must be enrolled in the same health plan as the benefit recipient. When both parents* are benefit recipients, either may elect to cover the dependents. **NOTE:** Dependents whose coverage was terminated for nonpayment of premium under one parent cannot be enrolled under the other until all premiums due for that dependent are paid.

Benefit recipients must complete the required enrollment forms to add dependent coverage. Forms are available on the Benefits website and the SURS website.

* The term 'parent' includes a stepparent or a civil union partner of the child's parent.

Documentation Requirements

Documentation, including the dependent's social security number (SSN), is always required to enroll dependents. Failure to provide the required documentation in the allotted time period will result in denial of dependent coverage. If denied, the eligible dependent may be added during the next Benefit Choice Period (if never previously enrolled in CIP) or upon the benefit recipient experiencing a qualifying change in status, as long as the documentation is provided in a timely manner.

An additional time period of 90 days is allotted to provide the SSN of newborns and adopted children; however, the election time frames still apply to request the addition of the dependent coverage. If the SSN is not provided within 90 days of the dependent's date of birth or adoption date, coverage will be terminated. Refer to the 'Documentation Requirements – Adding Dependent Coverage' chart later in this chapter for specific documentation requirements.

Dependent Beneficiary Enrollment Opportunities

Dependent beneficiaries may be enrolled in CIP during the annual Benefit Choice Period only if they have never been previously enrolled. The coverage becomes effective July 1st.

Outside the annual Benefit Choice Period, dependent beneficiaries who experience one of the following events may be enrolled in CIP, regardless of whether or not they have ever been previously enrolled:

- **The dependent beneficiary becomes eligible for Medicare.** Dependent beneficiaries who become

Enrollment Periods (cont.)

eligible for Medicare are eligible for CIP coverage. The coverage must be applied for within 6 months from the date the dependent beneficiary became Medicare eligible. If the dependent beneficiary is Medicare eligible due to turning 65 and wishes to be enrolled in CIP, the benefit recipient should contact SURS prior to their 65th birthday. Coverage will be effective the first day of the month in which the dependent beneficiary becomes Medicare eligible or the first day of the month when the enrollment application is received by SURS, whichever is later.

- **The dependent beneficiary has been determined to be ineligible for Medicare.** Dependent beneficiaries who have been determined by the Social Security Administration to be ineligible for Medicare have 30 days from their 65th birthday to apply for coverage. Coverage will be effective the first day of the month in which the dependent reaches age 65 or the first day of the month when the enrollment application is received by SURS, whichever is later.
- **Coverage is terminated by a former group plan.** Dependent beneficiaries who are eligible to enroll in CIP but instead continue coverage with another plan, may enroll if the other plan terminates coverage. The dependent has 30 days following the loss of other coverage to submit an enrollment application to SURS, along with a letter from the former plan stating the effective date of termination. Termination of coverage must be initiated by the former group plan. Termination for nonpayment of premium does not qualify as loss of coverage by the group plan and therefore is not an eligible enrollment event. The effective date of the coverage is the first day of the month following cancellation of coverage with the other plan.

College Insurance Program Enrollment Opportunities

Reason	Benefit Recipient may enroll in CIP for the first time	Benefit Recipient may enroll in CIP even if previously enrolled	Dependent Beneficiary may be enrolled in CIP for the first time	Dependent Beneficiary may be enrolled in CIP even if previously enrolled
Upon application of annuity benefits	X	N/A	X	
Benefit Recipient becomes eligible for Medicare (turning 65/ESRD/disability)	X	X	X	
Benefit Recipient determined ineligible for Medicare (turning 65)	X	X	X	
Benefit Recipient's coverage is involuntarily terminated by a former group plan	X	X	X	
Annual Benefit Choice Period	X		X	
Marriage, civil union, adoption or birth			X	
Dependent Beneficiary becomes eligible for Medicare (turning 65/ESRD/disability)			X	X
Dependent Beneficiary determined ineligible for Medicare (turning 65)			X	X
Dependent Beneficiary's coverage is involuntarily terminated by a former group plan			X	X

Documentation Requirements – Adding Dependent Coverage*

Type of Dependent	Supporting Documentation Required
Adjudicated Child Birth up to, but not including, age 26	• Judicial Support Order from a judge; or • Copy of DHFS Qualified Medical Support Order with the page that indicates the benefit recipient must provide health insurance through the retirement system
Adoption or Placement for Adoption Birth up to, but not including, age 26	• Adoption Decree/Order with judge's signature and the circuit clerk's file stamp, or a • Petition for adoption with the circuit clerk's file stamp
Adult Veteran Child Child age 26 up to, but not including, age 30	• Birth Certificate required, and • Proof of Illinois residency, and • Veterans' Affairs Release form DD-214 (or equivalent), and the • Eligibility Certification Statement (CMS-138), and a • Copy of the tax return
Disabled Child age 26 and older (onset of disability must have occurred prior to age 26)	• Birth Certificate required, and a • Letter from licensed physician detailing the dependent's limitations, ICD-9 diagnosis code, capabilities, date of onset of condition, and a • Statement from the Social Security Administration with the social security disability determination, and a • Copy of the Medicare card, and the • Eligibility Certification Statement (CMS-138), and a • Copy of the tax return
Legal Guardianship Birth up to, but not including, age 26	• Court Order with judge's signature and circuit clerk's file stamp
Natural Child Birth up to, but not including, age 26	• Birth Certificate required
Parent	• Benefit Recipient's Birth Certificate indicating the parent's name, and • Copy of the parent's Medicare card (if applicable), and • Eligibility Certification Statement (CMS-138), and a • Copy of the tax return
Spouse or Civil Union Partner	• Marriage Certificate or tax return • Civil Union Partnership Certificate.
Stepchild or Child of Civil Union Partner Birth up to, but not including, age 26	• Birth Certificate required, and • Marriage or Civil Union Partnership Certificate indicating the member is married to, or the partner of, the child's parent.

Note: Birth Certificate from either the State or admitting hospital which indicates the benefit recipient is the parent is acceptable.

* A valid social security number (SSN) is required to add dependent coverage. If the SSN has not yet been issued for a newborn or adopted child, the child will be added to the benefit recipient's coverage upon receipt of the birth certificate or adoption order without the SSN. The benefit recipient must provide the SSN within 90 days of the date the coverage was requested in order to continue the dependent's coverage.

Documentation Requirements – Terminating Dependent Coverage

Qualifying Event	Supporting Documentation Required
Divorce, Dissolution of Civil Union Partnership or Annulment	**Divorce Decree or Judgment of Dissolution or Annulment** filed in a U.S. Court – first and last pages with judge's signature with circuit clerk's file stamp.
Legal Separation	**Court Order** with judge's signature with circuit clerk's file stamp.
Loss of Court-Ordered Custody	**Court Order** indicating the member no longer has custody of the dependent. The order must have judge's signature with circuit clerk's file stamp.
Dependent Beneficiary Becomes Ineligible for Group Insurance Coverage	**Signed memorandum** from the benefit recipient indicating the dependent's name, the reason for the termination and the effective date of the termination.

Documentation Time Limits

Dependent coverage may be added with the corresponding effective date when documentation is provided to SURS within the allowable time frame as indicated below. If documentation is provided outside the time frames, adding dependent coverage will not be allowed until the next annual Benefit Choice Period (as long as the dependent has never previously been enrolled in CIP) or until the member experiences a qualifying change in status.

When adding Dependent coverage due to or during the:	If the coverage is requested…	And if the documentation is provided…	Dependent coverage will be effective…
Initial Enrollment Period	Day 1 – 30 from the benefit begin date	Day 1 – 30 from the benefit begin date	On the date of commencement of retirement or annuity benefits, or the first of the month of the application for retirement, whichever is later
Annual Benefit Choice Period (Normally held May 1 – May 31 each year)	During the Benefit Choice Period	Within 10 days of the Benefit Choice Period ending	July 1st
Qualifying Change in Status (Exception for birth or adoption – noted below)	Before, or the day of, the event Day 1 – 30 after event	1 – 30 days after the event	The first day of the month following the date of the event
Birth of Child (Natural or Adopted)	From birth up to 31 days after the birth	From birth to 31 days after the birth	Date of birth
Adopted Children (Other than newborn)	Within 31 days of the event	Within 31 days of the event	Date of placement of the child, filing of the petition or the entry of the adoption order

Penalty for Fraud

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under CIP is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the benefit recipient and/or the dependent beneficiary, as well as expenses incurred by CIP.

Premium Payment

The College Insurance Program (CIP) covers the majority of the cost of the benefit recipient's health, dental and vision insurance coverage. The amount a benefit recipient contributes each month is based upon the coverage elections in effect on the 1st of the month. Premiums will not be prorated when a benefit recipient changes their coverage elections or terminates from CIP on a day other than the 1st. Benefit recipients whose annuity check is insufficient to have premiums deducted will be direct billed. **It is your responsibility to verify the accuracy of premiums paid, whether deducted from the annuity or direct billed, and to notify SURS of any errors.**

All benefit recipients are responsible for the entire cost of elective dependent coverage. Premiums for dependent coverage are established annually and reflected in the Benefit Choice Options booklet. These contributions/premiums are subject to change each plan year.

Benefit Recipients Direct Billed

Billing Procedure and Time Frames

The law requires that the premium for coverage be deducted from the annuity received by the benefit recipient. If the annuity is insufficient to cover the premium, a direct bill statement will be sent which requires the benefit recipient to submit monthly payments. Premium payment is required through the month of cancellation or death.

Nonpayment of Premium

If payment is not received by the final due date, coverage will be terminated effective the last day of the current month. **Failure to pay the bill may result in a loss of coverage and/or withholding through the SURS annuity check.**

Please be advised that benefit recipients and their dependents who are terminated for nonpayment of premium will not be eligible to re-enroll in CIP, or be covered under another member, nor are they eligible for continuation of coverage through COBRA.

COBRA Participants

While a plan participant is on COBRA, a monthly bill is generated by SURS for the premium amount due. Bills are mailed the first week of each month and must be paid by the due date to ensure continuation of coverage. Plan participants who do not receive a bill should contact SURS for assistance. Failure to submit payment will result in termination of coverage retroactive to midnight the last day of the month for which full payment was received.

Premium Refunds

Premium refunds based on corrections to a benefit recipient's insurance elections may be processed retroactively up to six months. Benefit recipients who fail to notify SURS within 30 days of a dependent's ineligibility will not receive a premium refund.

Premium Underpayments

Underpaid premiums are the responsibility of the annuitant or survivor and must be paid in full, regardless of the time period for which the underpayment occurred.

Penalty for Fraud

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under CIP is considered a fraudulent act. The State of Illinois will impose a financial penalty, including, but not limited to, repayment of all premiums the State made on behalf of the benefit recipient and/or the dependent beneficiary, as well as expenses incurred by CIP.

Termination

The coverage of a benefit recipient and any dependents will terminate upon the request of the benefit recipient, the benefit ceasing, the benefit recipient's death or upon the coverage being terminated for nonpayment of premium. When a dependent experiences an event which terminates their coverage, such as a benefit recipient's death, the dependent's health, dental and vision coverage, in most cases, can be continued under the Consolidated Omnibus Budget Reconciliation Act (COBRA). See the 'COBRA Coverage' section for more information.

Termination of the Benefit Recipient's Coverage

A benefit recipient's coverage terminates at midnight:

- On the date of benefit recipient's death.
- On the last day of the month for which payment is not received following the issuance of a final notice of premium due from SURS (member and all dependents will be ineligible for COBRA).
- On the last day of the month in which the benefit recipient's annuity benefit ceases.
- On the last day of the month in which the benefit recipient requested the termination of coverage.

Termination of Dependent Beneficiary's Coverage

An enrolled dependent's coverage terminates at midnight:

- Simultaneous with termination of the benefit recipient's coverage.
- On the last day of the month in which the benefit recipient requested termination of the dependent's coverage.
- On the last day of the month in which a dependent loses eligibility.
- On June 30th for dependents who are voluntarily terminated during the Benefit Choice Period (these dependents will be ineligible for COBRA).
- On the last day of the month following receipt of the written request to terminate dependent coverage. **Re-enrollment opportunities are limited – see the enrollment section for details** (these dependents will be ineligible for COBRA).
- On the date of dependent's death.
- On the last day of the month in which the benefit recipient fails to certify continued eligibility for coverage of the dependent child.
- On the day preceding the dependent's:
  - enrollment in CIP as a benefit recipient.
  - divorce or civil union partnership dissolution from the benefit recipient. The divorce or civil union partnership dissolution terminates the coverage for the spouse or civil union partner and all applicable stepchildren or children of the civil union partner.

NOTE: Benefit recipients who fail to notify SURS within 30 days of the dependent's ineligibility will not receive a premium refund, nor will the dependent be eligible for COBRA.

COBRA Coverage

Overview

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Sections 367.2, 367e and 367e.1 of the Illinois Insurance Code provides eligible covered benefit recipients and their eligible dependents the opportunity to **temporarily** extend their health coverage when coverage under the health plan would otherwise end due to certain qualifying events. COBRA rights are restricted to certain conditions under which coverage is lost. The election to continue coverage must be made within a specified election period. If elected, coverage will be reinstated retroactive to the date following termination of coverage.

An initial notice is provided to all new members upon enrollment in CIP. This notice is to acquaint individuals with COBRA law, notification obligations and possible rights to COBRA coverage if loss of group health coverage should occur. If an initial notice is not received, benefit recipients should contact SURS.

Eligibility

Covered benefit recipients and dependents who lose coverage due to certain qualifying events (see the 'COBRA Qualifying Events' chart at the end of this section) are considered qualified beneficiaries and may be allowed to continue coverage under the provisions of COBRA. A **qualified beneficiary** is an individual (including the member, spouse, civil union partner or child) who loses employer-provided group health coverage and is entitled to elect COBRA coverage. The individual must have been covered by the plan on the day before the qualifying event occurred and enrolled in COBRA effective the first day of eligibility or be a newborn or newly adopted child of the covered member. **Any voluntary termination of coverage will render the benefit recipients and any dependents ineligible for COBRA coverage**.

Coverage available under COBRA for qualified beneficiaries is identical to the health, dental and vision insurance coverage provided to CIP members.

Covered dependents retain COBRA eligibility rights even if the benefit recipient chooses not to enroll. Qualified beneficiaries electing continuation of coverage under COBRA will be enrolled as a member. **NOTE: If the benefit recipient's spouse, civil union partner or dependent child(ren) live at another address, SURS must be advised immediately so that notification can be sent to the proper address(es).**

Notification of COBRA Eligibility

The benefit recipient or qualified beneficiary must notify SURS within 60 days of the date of the termination event, or the date on which coverage would end, whichever is earlier. Failure to notify SURS within 60 days will result in disqualification of COBRA continuation coverage.

SURS will send a letter to the qualified beneficiary regarding COBRA rights within 14 days of receiving notification of the termination. Included with the letter will be an enrollment form, premium payment information and important deadlines. If a letter is not received within 30 days and you notified SURS within the 60-day period, you should contact the retirement system immediately for information.

COBRA Enrollment

Individuals have 60 days from the date of the COBRA eligibility letter to elect enrollment in COBRA and 45 days from the date of election to pay all premiums. Failure to complete and return the enrollment form or to submit payment by the due dates will terminate COBRA rights. If the enrollment form and all required payments are received by the due dates, coverage will be reinstated retroactive to the date of the qualifying event.

Medicare or Other Group Coverage - Impact on COBRA

Qualified beneficiaries who become eligible for Medicare or obtain other group insurance coverage (which does not impose preexisting condition limitations or exclusions) after enrolling in COBRA are required to notify the Department in writing of their Medicare eligibility or other group coverage. These individuals are ineligible to continue COBRA coverage and will be terminated from the COBRA program.

SURS reserves the right to retroactively terminate COBRA coverage if an individual is deemed ineligible. Premiums will not be refunded for coverage terminated retroactively due to ineligibility.

COBRA Extensions

✦ Disability Extension

Qualified beneficiaries covered under COBRA who have been determined to be disabled by the Social Security Administration (SSA) may be eligible to extend coverage from 18 months to 29 months at an increased

COBRA Coverage (cont.)

cost. Enrolled nondisabled family members are also eligible for the extension. See 'Premium Payment under COBRA' later in this section for premium information.

To be eligible for the extension, the qualified beneficiary must either (1) become disabled during the first 60 days of COBRA continuation coverage or (2) been determined disabled prior to the date of COBRA eligibility. In either case, the determination must have been made by the Social Security Administration (SSA) and a copy of the SSA determination letter must be submitted to SURS within 60 days of the date of the SSA determination letter or the first day of COBRA coverage, whichever is later.

The affected qualified beneficiary must also notify SURS of any SSA final determination loss of disability status. This notification must be provided **within 30 days** of the SSA determination letter.

✦ Second Qualifying Event Extension

If a member who experienced a qualifying event that resulted in an 18-month maximum continuation period experiences a second qualifying event before the end of the original 18-month COBRA coverage period, the spouse, civil union partner and/or dependent child (must be a qualified beneficiary) may extend coverage an additional 18 months for a maximum of 36 months.

Waiver of COBRA Rights and Revocation of that Waiver

A qualified beneficiary may waive rights to COBRA coverage during the 60-day election period and can revoke the waiver at any time before the end of the 60-day period. Coverage will be retroactive to the qualifying event.

Premium Payment under COBRA

The qualified beneficiary has 45 days from the date coverage is elected to pay all premiums. Individuals electing COBRA are considered members and will be charged the member rate. A divorced or widowed spouse (including a former civil union partner) who has a dependent child on their coverage would be considered the member and charged the member rate, with the child being charged the applicable dependent rate. If only a dependent child elects COBRA, then each child would be considered a member and charged the member rate.

Once the COBRA enrollment form is received by SURS and the premium is paid, coverage will be reinstated retroactive to the date coverage was terminated. SURS will mail monthly billing statements to the member's address on file on or about the 5th of each month. Bills for the current month are due by the 25th of the same month. Final notice bills (those with a balance from a previous month) are due by the 20th of the same month. Failure to pay the premium by the final due date will result in termination of coverage retroactive to the last day of the month in which premiums were paid.

It is the member's responsibility to promptly notify SURS in writing of any address change or billing problem.

The College Insurance Program does not contribute to the premium for COBRA coverage. Most COBRA members must pay the applicable premium plus a 2% administrative fee for participation. COBRA members who extend coverage for 29 months due to SSA's determination of disability must pay the applicable premium plus a 50% administrative fee for all months covered beyond the initial 18 months.

COBRA Coverage (cont.)

Adding Dependents - Second Qualifying Event Limitations

Newly-acquired dependents, including spouses, civil union partners, children of civil union partners and stepchildren, may be added to existing COBRA coverage. Even though these dependents are eligible for COBRA coverage, unless they are a newborn child or a newly adopted child, they are not considered "qualified beneficiaries" and therefore would be ineligible for an extension if a second qualifying event would occur.

Existing dependents who are not enrolled on the first day the benefit recipient becomes eligible for COBRA continuation coverage are not considered qualified beneficiaries. These dependents may only be added during the annual Benefit Choice Period (if they have never previously been enrolled in CIP) and are also not eligible for second qualifying event extensions.

Documentation requirements must be met to add dependents. See the 'Documentation Requirements – Adding Dependent Coverage' chart in this chapter for details.

Termination of Coverage under COBRA

COBRA coverage terminates when the earliest of the following occurs:

- Maximum continuation period ends.
- Failure to make timely payment of premium.
- Covered member or dependent becomes a participant in another group health plan which does not impose a preexisting condition exclusion or limitation (for example, through employment or marriage).
- Covered member or dependent becomes entitled to Medicare. Special rules apply for End-Stage Renal Disease. Contact SURS for more information.
- Covered member or dependent reaches the qualifying age for Medicare.
- Covered dependent gets divorced from COBRA member (includes when the COBRA member's civil union partnership with the covered dependent is dissolved).
- Covered dependent child loses eligibility.
- Upon the member's death for any dependent not considered a qualified beneficiary.

Refer to the 'COBRA Qualifying Events' chart in this chapter for more information.

Conversion Privilege for Health Coverage

When COBRA coverage terminates, members may have the right to convert to an individual health plan. This conversion privilege applies to health coverage only. Members are eligible for this conversion unless group health coverage ended because:

- the required premium was not paid, or
- the coverage was replaced by another group health plan, including Medicare, or
- the COBRA coverage was voluntarily terminated.

Approximately two months before COBRA coverage ends, SURS will send a letter providing instructions on how to apply for conversion. To be eligible for conversion, members must have been covered by the current COBRA health plan for at least 3 months and requested conversion within 31 days of exhaustion of COBRA coverage. The converted coverage, if issued, will become effective the day after COBRA coverage ended. Contact the appropriate health plan administrator for information regarding conversion. SURS is not involved in the administration or premium rate structure of coverage obtained through conversion.

COBRA Coverage (cont.)

COBRA QUALIFYING EVENTS

A COBRA qualifying event is any of the events shown below that result in a loss of coverage.
The term 'Spouse' in this chart includes civil union partners; 'Ex-spouse' includes civil union partners whose partnership has been dissolved.

Qualifying Events	Maximum Eligibility Period
BENEFIT RECIPIENT	
Benefit Recipient's loss of eligibility	18 months
DEPENDENT BENEFICIARY	
Benefit Recipient's termination of benefits	18 months
Legal separation from Benefit Recipient*	36 months
Loss of eligibility as a dependent child	36 months
Benefit Recipient's death	
• Spouse under age 55	36 months
• Spouse age 55 or older if already enrolled in Medicare	36 months
• Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Dependent child	36 months
Dissolution of Marriage or Civil Union Partnership*	
• Ex-Spouse under age 55	36 months
• Ex-Spouse age 55 or older if already enrolled in Medicare	36 months
• Ex-Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Stepchild or Child of a Civil Union Partner	36 months

* Dropping a spouse's coverage during the annual Benefit Choice Period in anticipation of a divorce, civil union partnership dissolution or legal separation will result in the spouse losing coverage effective July 1st. The spouse will be eligible for COBRA only once the divorce, dissolution or legal separation actually occurs. Spouses whose coverage was terminated due to a divorce, dissolution or legal separation must contact our office within 30 days of the event in order to be offered COBRA coverage.

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under COBRA is considered a fraudulent act. Premiums paid will not be refunded for coverage terminated retroactively due to ineligibility.

COBRA Coverage (cont.)

A qualified beneficiary is an individual (including the member, spouse, civil union partner or child) who loses employer-provided group health coverage and is entitled to elect COBRA coverage. The individual must have been covered by the plan on the day before the qualifying event occurred and enrolled in COBRA effective the first day of eligibility or be a newborn or newly adopted child of the covered member.

SECOND QUALIFYING EVENTS

The events shown below will extend coverage for a **qualified beneficiary** if it occurs during the original 18-month COBRA period.

The term 'Spouse' in this chart includes civil union partners; 'Ex-spouse' includes civil union partners whose partnership has been dissolved.

Qualifying Events	Maximum Eligibility Period
COBRA MEMBER	
SSA Disability determination within the first 60 days of COBRA	Additional 11 months for a maximum of 29 months
COBRA DEPENDENT	
Loss of eligibility as a dependent child	Additional 18 months for a maximum of 36 months
Legal separation from COBRA member*	Additional 18 months for a maximum of 36 months
COBRA member's death	
• Spouse under age 55	
• Spouse age 55 or older if already enrolled in Medicare	
• Spouse age 55 or older	Until obtains Medicare or reaches the qualifying age for Medicare
• Dependent child	Additional 18 months for a maximum of 36 months
Divorce from/Dissolution of civil union partnership with COBRA member*	
• Ex-Spouse under age 55	
• Ex-Spouse age 55 or older if already enrolled in Medicare	
• Ex-Spouse age 55 or older	
• Stepchild or Child of Civil Union Partner	Additional 18 months for a maximum of 36 months

* Dropping a spouse's coverage during the annual Benefit Choice Period in anticipation of a divorce, civil union partnership dissolution or legal separation will result in the spouse losing coverage effective July 1st. The spouse will be eligible for COBRA only once the divorce, dissolution or legal separation actually occurs. Spouses whose coverage was terminated due to a divorce, dissolution or legal separation must contact our office within 30 days of the event in order to be offered COBRA coverage.

Falsifying information/documentation or failing to provide information/documentation in order to obtain/continue coverage under COBRA is considered a fraudulent act. Premiums paid will not be refunded for coverage terminated retroactively due to ineligibility.

Chapter 2

Chapter 2: Health, Dental and Vision Coverage Information

Health Plan Options

Overview

College Insurance Program (CIP) offers a variety of health plans from which to choose. Each plan provides health, behavioral health and prescription drug benefits; however, the benefit levels, exclusions and limitations differ. When making choices, benefit recipients should consider health status, coverage needs and service preferences. Dependents will have the same health and dental plan as the benefit recipient under whom they are enrolled.

The annual Benefit Choice Options booklet provides a listing of the health plans available and the Illinois counties in which they provide coverage.

Types of Health Plans

The types of health plans available are:

- Managed Care Plans
  - Health Maintenance Organizations (HMOs)
  - Open Access Plans (OAPs)
- College Choice Health Plan (CCHP)

Disease Management Programs and Wellness Offerings

Disease management programs are utilized by the health plans as a way to improve the health of plan participants. Plan participants may be contacted by their health plan to participate in these programs.

Wellness options and preventive measures are offered and encouraged by the health plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help plan participants take control of their personal health and well-being. Information about the various offerings is available on the plan administrators' websites.

Managed Care Health Plans

Managed care is a method of delivering healthcare through a system of network providers. Managed care plans provide comprehensive health benefits at lower out-of-pocket costs by utilizing network providers. Managed care health plans coordinate all aspects of a plan participant's healthcare including medical, prescription drug and behavioral health services.

There are two types of managed care plans, health maintenance organizations (HMOs) and open access plans (OAPs). Benefit recipients who enroll in an HMO must select a primary care physician/provider (PCP) from the health plan's provider directory, which can be found on the plan's website. Plan participants should contact the physician's office or the HMO plan administrator to find out if the PCP is accepting new patients. Plan participants are required to use participating physicians and hospitals for maximum benefits. Benefit recipients enrolled in an OAP do not need to select a PCP. For complete information on specific plan coverage or provider networks, contact the managed care health plan and review the SPD.

Ordinarily, managed care plans only cover members within the State; however, plans that have networks outside the State of Illinois may provide coverage. Members should contact the managed care plan administrator to ascertain if coverage is available outside their geographic area. Eligible dependents that live apart from the benefit recipient's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on out-of-area coverage.

The open access care health plans are self insured, meaning all claims are paid by CIP even though managed care health plan benefits apply. These plans are not regulated by the Illinois Department of Insurance and are not governed by the Employees Retirement Income Security Act (ERISA).

In order to have the most detailed information regarding a particular managed care health plan, benefit recipients should ask the plan administrator for its summary plan description (SPD) which describes the covered services, benefit levels, and exclusions and limitations of the plan's coverage. The SPD may also be referred to as a certificate of coverage or a summary plan document.

Benefit recipients should pay particular attention to the managed care plan's exclusions and limitations. It is important that plan participants understand which services are not covered under the plan. Members deciding to enroll in a managed care health plan should read the SPD before seeking medical attention. It is the plan participant's responsibility to become familiar with all of the specific requirements of the health plan.

Health Plan Options (Managed Care Health Plans cont.)

Most managed care health plans impose benefit limitations on a plan year basis (July 1 through June 30); however, some managed care health plans impose benefit limitations on a calendar year basis (January 1 through December 31).

Refer to the annual Benefit Choice Options booklet for plan administrator information.

Health Maintenance Organization (HMO)

HMO members must choose a primary care physician/ provider (PCP) who will coordinate the healthcare, hospitalizations and referrals for specialty care. In most cases a referral for specialty care will be restricted to those services and providers authorized by the designated PCP. Additionally, referrals may also require prior authorization from the HMO. To receive the maximum hospital benefit, your PCP or specialist must have admitting privileges to a network hospital.

Like any health plan, HMOs have plan limitations including geographic availability and participating provider networks. HMO coverage is offered in certain counties called service areas. There is no coverage outside these service areas unless preapproved by the HMO. When traveling outside of the health plan's service area, coverage is limited to life-threatening emergency services. For specific information regarding out-of-area services or emergencies, call the plan administrator. **NOTE:** When an HMO plan is the secondary plan and the plan participant does not utilize the HMO network of providers or does not obtain the required referral, the HMO plan is not required to pay for services. Refer to the plan's description of coverage for additional information.

Managed care health plan provider networks are subject to change. Benefit recipients will be notified in writing by the plan administrator when a PCP network change occurs. Benefit recipients will have 30 days from the date the provider leaves the network to make a health plan change. If the designated PCP leaves the HMO network*, you must choose another PCP within that plan.

When an HMO member's primary care physician (PCP) leaves the plan's network, the member will only be allowed to change health plans if the HMO network experienced a significant change in the number of medical providers offered, as determined by CMS.

Benefit recipients who change their health plan outside the Benefit Choice Period, regardless of the basis for the change, will be responsible for any deductibles required by the new plan, even if the plan participant met all deductibles while covered by the previous health plan.

* The opportunity to change health plans applies only when the PCP leaves the network. This opportunity does not apply to specialists or womens' healthcare providers who are not the designated PCP, nor does it apply when a hospital leaves the network.

HMO Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year for eligible medical, behavioral health and prescription drug charges. Charges that apply toward the out-of-pocket maximum for HMOs are:

- Medical and prescription copayments
- Medical coinsurance.

Open Access Plans (OAPs)

Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. Members who elect an OAP will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted. Members enrolled in an OAP can mix and match providers and tiers.

- Tier I offers a managed care network which provide enhanced benefits and require copayments which mirror HMO copayments.
- Tier II offers another managed care network, in addition to the managed care network offered in Tier I, and also provides enhanced benefits. Tier II requires copayments, coinsurance and is subject to an annual plan year deductible.
- Tier III covers all providers which are not in the managed care network of Tiers I or II (i.e., out of network providers) and does not have an out-of-pocket maximum. Using Tier III can offer members flexibility in selecting healthcare providers, but involve higher out-of pocket costs. Tier III has a higher plan year deductible and has a higher coinsurance amount than Tier II services. In addition, certain services, such as preventive/wellness care, are not covered when obtained under Tier III. Furthermore, plan participants who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services (i.e., allowable charges), which could result in much higher out-of-pocket costs. When using out-of-network providers, it is recommended that the participant obtain a preauthorization of benefits to ensure that medical services/stays will meet medical necessity criteria and be eligible for benefit coverage.

Health Plan Options (Managed Care Health Plans cont.)

Members who use providers in Tiers II and III will be responsible for the plan year deductible. **In accordance with the Affordable Care Act, these deductibles will accumulate separately from each other and will not 'cross accumulate.'** This means that amounts paid toward the deductible in one tier will not apply toward the deductible in the other tier.

OAP Out-of-Pocket Maximum

Eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year after the plan's out-of-pocket maximum has been satisfied. Charges that apply toward the out-of-pocket maximum for an OAP plan (only applies to Tier I and Tier II providers) are:

- Annual medical plan year deductible (Tier II).
- Medical and prescription copayments
- Medical coinsurance.

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

College Choice Health Plan (CCHP)

The College Choice Health Plan (CCHP) is a self-insured health plan offering a comprehensive range of benefits. All claims and costs are paid by the College Insurance Program (CIP) through a third-party administrator. For complete information regarding specific plan coverage and the provider's network, refer to the summary plan description on the Benefits website. Benefit enhancements are available by utilizing the:

- Nationwide CCHP physician, hospital, ancillary services and transplant network.
- Pharmacy network.
- Behavioral health network.

Each of these three components is discussed separately in this section. Each component has its own plan administrator.

Benefit Recipient Responsibilities

- **The benefit recipient is always responsible for:**
  - Any amount required to meet **plan year deductibles, additional deductibles** and **coinsurance** amounts.
  - Any amount over the **allowable charges**.
  - Any penalties for failure to comply with the **notification requirements**.
  - Any charges NOT covered by the plan or determined by the plan administrator to be not **medically necessary** services.

NOTE: Specific dollar amounts and percentages that apply to deductibles, "additional deductibles" and coinsurance are updated each year in the Benefit Choice Options booklet.

Plan Requirements

Plan Year Deductible

The plan year deductible requirement applies to all medical and behavioral health services, except preventive services. The plan year deductible for benefit recipients is a set amount that may change each plan year. **To verify individual and family plan year deductible**, review the current Benefit Choice Options booklet. The plan year runs from July 1 through June 30.

Each family member's plan year deductible will accumulate toward a family plan year deductible. Once the family as a unit has satisfied the family plan year deductible, no further plan deductibles for any family member will be required for eligible charges incurred for the remainder of that plan year. The individual plan year deductible and/or the family plan year deductible accumulate toward the annual out-of-pocket maximum.

Additional Deductibles

Besides the plan year deductible, plan participants must pay additional deductibles for the following:

- Each emergency room visit that does not result in a hospital admission
- Hospital admission (CCHP and non-CCHP)
- Transplant hospital admission

Even though these additional deductibles do not apply toward the plan year deductible, they do accumulate toward the annual out-of-pocket maximum.

Health Plan Options (College Choice Health Plan (CCHP))

Coinsurance

Coinsurance is the percentage of eligible charges that plan participants must pay after the annual plan year deductible has been met. Eligible charges are charges for covered services and supplies which are medically necessary.

CCHP Out-of-Pocket Maximum

Eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year after the plan's out-of-pocket maximum has been satisfied. There are two separate out-of-pocket maximums: in-network and out-of-network. Coinsurance and deductibles apply to one or the other, but not both. Charges that apply toward the out-of-pocket maximum for the CCHP plan are:

- Annual medical plan year deductible
- Prescription copayments
- Medical coinsurance
- CCHP additional medical deductibles

The following do not apply toward out-of-pocket maximums:

- Notification penalties.
- Ineligible charges (i.e., amounts over the allowable charge, charges for noncovered services and charges for services deemed not to be medically necessary).

Medical Necessity

- **CCHP covers charges for services and supplies that are medically necessary. Medically necessary services and supplies are those which are:**
  - provided by a hospital, medical facility or prescribed by a physician or other provider and are required to identify and/or treat an illness or injury.
  - consistent with the symptoms or diagnosis and treatment of the condition (including pregnancy), disease, ailment or accidental injury.
  - generally accepted in medical practice as necessary and meeting the standards for good medical practice for the diagnosis or treatment of the patient's condition.
  - the most appropriate supply or level of service which can be safely provided to the patient.
  - not solely for the convenience of the patient, physician, hospital or other provider.
  - repeated only as indicated as medically appropriate.
  - not redundant when combined with other treatment being rendered.

Predetermination of Benefits

Predetermination of benefits ensures that medical services/stays will meet medical necessity criteria and be eligible for benefit coverage. The plan participant's physician must submit written detailed medical information to the medical plan administrator. For questions regarding a predetermination of benefits, contact the plan administrator.

Benefits are based on the plan participant's eligibility and plan provisions in effect at the time services are rendered. Precise claim payment amounts can only be determined upon receipt of the itemized bill and are subject to standard claim payment policies including, but not limited to, multiple and incidental procedure reductions, allowable charges and claim bundling and unbundling of procedures.

Allowable Charges

The maximum amount the plan will pay an out-of-network healthcare professional for billed services is referred to as allowable charges. The amount that is over the allowable charges amount is not considered eligible for payment by the plan and therefore cannot be applied to the plan year deductible nor the out-of-pocket maximum. **The plan participant will be responsible for the entire amount that is over and above the allowable charges amount. Allowable charges are usually applied when using out-of-network providers.**

When processing any given claim, the plan administrator takes the following into account:

- Complexity of the services.
- Any unusual circumstances or complications that require additional skill, time or experience.
- Prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical-cost experience.

Allowable charges apply to medical services, procedures and/or supplies.

IMPORTANT: The amount of the claim that will be paid is based on the allowable charges amount or the actual charge made by the provider, whichever is less, for out-of-network services.

Health Plan Options (CCHP cont.)

College Choice Health Plan (CCHP) Network

The College Choice Health Plan (CCHP) network includes hospitals, physicians and ancillary providers throughout Illinois, as well as nationwide. The network provides quality inpatient and outpatient care at negotiated rates, which result in savings to plan participants. The network is subject to change any time during the plan year.

Medical Case Management

The Medical Case Management (MCM) Program is designed to assist plan participants requiring complex care in times of serious or prolonged illness. There is no additional cost to the plan participant for this service.

The referral to the MCM Program is made through either the MCM administrator, the CCHP plan administrator or by request from a plan participant. Once referred, the plan participant is assigned a case manager who serves as a liaison and facilitator between the patient, family, physician and other healthcare providers. The case manager is a registered nurse or other healthcare professional with extensive clinical background. The case manager can effectively minimize the fragmentation of care.

Upon completing the MCM review, the case manager will make a recommendation regarding the treatment setting, intensity of services and appropriate alternatives of care. To reach the MCM plan administrator, call the toll-free number listed in the plan administrator section of the current Benefit Choice Options booklet located on the Benefits website.

Notification Requirements

Notification is the telephone call to the notification administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility or for an outpatient procedure, therapy service or supply. If using a CCHP network provider, the medical provider is responsible for contacting the notification administrator on behalf of the plan participant.

If using a non-CCHP provider, the plan participant may request that their non-CCHP medical provider contact the notification administrator to provide specific medical information, setting and anticipated length of stay to determine medical appropriateness. The plan participant may also make notification, after which a medically qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information.

Regardless of where services are rendered, it is the plan participant's responsibility to ensure that notification has occurred. Failure to contact the notification administrator prior to having a service performed may result in a financial penalty and risk incurring noncovered charges. Notification is required for all plan participants including those with Medicare or other insurance as primary payer.

Contact information for the notification administrator can be found in the plan administrator section of the current Benefit Choice Options booklet. The toll-free number is also printed on your identification card. You can call seven days a week, twenty-four hours a day.

- **Notification is required for the following:**

  (Contact the notification administrator for the most up-to-date list of procedures requiring notification).

  - **Outpatient Surgery, Procedures, Therapies and Supplies/Equipment.** Outpatient surgery and procedures include, but are not limited to, items such as imaging (MRI, PET, SPECT and CAT scan), physical, occupational or speech therapy, foot orthotics, durable medical equipment (DME) supplies, infertility surgery, cardiac or pulmonary rehabilitation, skin removal or enhancement (lipectomy, select injectable drug treatment for varicose veins, etc.).
  - **Any Elective Inpatient Surgery or Non-Emergency Admission.** Notification must be made at least seven days before admission. The admission and length of stay must be authorized before entering the facility.
  - **Skilled Nursing Facility, Extended Care Facility or Nursing Home Admission.** Notification must be made at least seven days before admission. A review of the care being rendered will be conducted to determine if the services are skilled in nature.
  - **Emergency or Urgent Admission.** Notification must be made within two business days after the admission.
  - **Hospice Admission.** Notification must be made prior to the admission.
  - **Potential Transplants.** Notification must be made prior to beginning evaluation services. Benefits are only available through the CCHP transplant network of hospitals/facilities.

- **Notification is *Not:***

  - **A final determination of medical necessity**. If the notification administrator should determine that the

Health Plan Options (CCHP cont.)

setting and/or anticipated length of stay are no longer medically necessary and NOT eligible for coverage, the physician will be informed immediately. The plan participant will also receive written confirmation of this determination.

- **A guarantee of benefits**. Regardless of notification of a procedure or admission, there will be no benefit payment if the plan participant is ineligible for coverage on the date services were rendered or if the charges are deemed ineligible.
- **Enrollment of a newborn for coverage**. Contact SURS to enroll a newborn within 31 days of birth.
- **A determination of the amount which will be paid for a covered service**. Benefits are based upon the plan participant's eligibility status and the plan provisions in effect at the time the services are provided.

NOTE: For authorization procedures and time limits for behavioral health services, see the 'Behavioral Health' section later in this chapter.

Benefits for Services Received While Outside the United States

The plan covers eligible charges incurred outside of the United States for services that are generally accepted as medically necessary within the United States. All plan benefits are subject to plan provisions and deductibles. The benefit for facility and professional charges is paid at the non-CCHP rate. Notification is not required for medically necessary services rendered outside of the United States; however, medical necessity must be established prior to reimbursement. **Payment for the services will most likely be required from the member at the time the services are rendered.**

Plan participants must file a claim with the plan administrator for reimbursement. When filing a claim, enclose the itemized bill with a description of the services translated to English and the total amount of billed charges, along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number. Reimbursement in American dollars will be based on the conversion rate of the billed currency on the date services were rendered.

Generally, Medicare will not pay for healthcare obtained outside the United States and its territories. When Medicare does not pay, CCHP becomes the primary payer and standard benefit levels will apply.

Hospital Bill Audit Program

The Hospital Bill Audit Program applies to CCHP and non-CCHP hospital charges. Under the program, a member or dependent who discovers an error or overcharge on a hospital bill and obtains a corrected bill is eligible for 50% of the resulting savings. There is no cap on the savings amount. Related nonhospital charges, such as radiologists and surgeons are not eligible charges under this program. This program applies only when CCHP is the primary payer.

Reimbursement documentation required:

- Original incorrect bill,
- Corrected copy of the bill, and
- Benefit recipient's name, telephone number and last four digits of the SSN.

Submit Documentation to:

Hospital Bill Audit Program
DCMS Group Insurance Division
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

College Choice Health Plan – Medical Benefits Summary

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 80% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

This document contains a brief overview of some of the benefits available under the College Choice Health Plan (CCHP). Contact the plan administrator for more information or coverage requirements and/or limitations. **In order for any service, therapy or supply to be considered eligible for coverage, it must be medically necessary as determined by the plan administrator. The information below indicates the requirements and benefit levels of the covered services, supplies and therapies for the standard benefit level (60% of allowable charges). There is a 80% enhanced benefit level for utilizing network providers.**

Ambulance (See Exclusion #5 and #43)

- Transportation charges to the nearest hospital/facility for emergency medically necessary services for a patient whose condition warrants such service. The plan administrator should be notified as soon as possible for a determination of coverage. Medically necessary transportation charges (emergency ground or air ambulance) will be paid at the 80% benefit level after the annual plan year deductible has been met. Services that are determined not to be medically necessary will not be covered.
- Transportation services eligible for coverage:
  - From the site of the disabling illness, injury, accident or trauma to the nearest hospital qualified to provide treatment (includes air ambulance when medically necessary).
  - From a remote area, by air, land or water (inside or outside the United States), to the nearest hospital qualified to provide emergency medical treatment.
  - From a facility which is not equipped to treat the patient's specific injury, trauma or illness to the nearest hospital equipped to treat the injury, trauma or illness.

Behavioral Health

In an emergency or a life-threatening situation, call 911, or go to the nearest hospital emergency room. Plan participants must call the behavioral health plan administrator within 48 hours to avoid a financial penalty. Authorization requirements still apply when plan participants have other coverage, such as Medicare.

- **Inpatient services** must be authorized prior to admission or within 48 hours of an emergency admission to receive in-network or out-of-network benefits. Authorization is required with each new admission. Failure to notify the behavioral health plan administrator of an admission to an inpatient facility within 48 hours will result in a financial penalty and risk incurring noncovered charges.
- **Partial hospitalization and intensive outpatient treatment** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required before beginning each treatment program. Failure to notify the behavioral health plan administrator of a partial hospitalization or intensive outpatient program will result in a financial penalty and risk incurring noncovered charges.
- **Outpatient services** received at the in-network benefit level must be provided by a CCHP network provider. Most routine outpatient services (such as therapy sessions and medication management) will be covered without the need for prior authorization. Authorization requirements for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a plan participant's condition will be subject to a medical necessity review. The behavioral health administrator will contact the plan participant's provider to discuss the treatment if a review will be applied. Outpatient services received at the out-of-network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or psychiatrist to be eligible for coverage.
- **Electroconvulsive therapy, psychological testing and applied behavioral analysis** must be authorized to receive in-network or out-of-network benefits. Failure to obtain authorization will result in the risk of incurring noncovered charges.
- **Residential services** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required with each new

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residential admission. Failure to notify the behavioral health plan administrator of an admission to a residential facility will result in a financial penalty and risk incurring noncovered charges.

Breast Reconstruction Following Mastectomy

- The plan provides coverage, subject to and consistent with all other plan provisions, for services following a mastectomy, including:
  - Reconstruction of the breast (including implants) on which the mastectomy was performed.
  - Surgery and reconstruction on the other breast (including implants) to produce a symmetrical appearance.
  - Prosthesis and treatment for any physical complications at any stage of mastectomy, including post-surgical lymphedema (swelling associated with the removal of lymph nodes) rendered by a provider covered under the plan.
  - Mastectomy bras are covered following surgery or a change in prosthesis.

Cardiac Rehabilitation

- Phase I and Phase II when ordered by a physician.

Chiropractic Services

- Maximum of thirty (30) visits per plan year will be covered.
- No coverage for chiropractic services considered to be maintenance in nature, in that medical information does not document progress in the improvement of the condition.

Christian Science Practitioner

- Coverage for the services of a Christian Science Nurse or Practitioner.
  - A Christian Science Nurse is a nurse who is listed in a Christian Science Journal at the time services are given and who: (a) has completed nurses' training at a Christian Science Benevolent Association Sanitarium; or (b) is a graduate of another School of Nursing; or (c) had three consecutive years of Christian Science Nursing, including two years of training.
  - A Christian Science Practitioner is an individual who is listed as such in the Christian Science Journal at the time the medical services are provided and who provides appropriate treatment in lieu of treatment by a medical doctor.

Circumcision

- Charges for professional services.
- Charges for circumcision are considered to be covered services when billed as a separate claim for the newborn as long as the newborn is enrolled in the plan and the surgery is performed within the first thirty (30) days following birth.

Dental Services (See Exclusion #14 and # 15)

- **Accidental Injury:**
  - Coverage for professional services necessary as a result of an accidental injury to sound natural teeth caused by an external force. Care must be rendered within three months of original accidental injury. The appropriate facility benefit applies.
- **Nonaccidental:** Coverage limited to:
  - Anesthesia and facility charges for dependent children age six and under.
  - A medical condition that requires anesthesia and facility charges for dental care (not anxiety or behavioral related conditions). Professional services are not covered under the medical plan.

Diabetic Coverage

- Charges for dietitian services and consultation when diagnosed with diabetes. No coverage unless ordered in conjunction with a diagnosis of diabetes.
- Charges for routine foot care by a physician when diagnosed with diabetes.
- Charges for insulin pumps and related supplies when deemed medically necessary.

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Dialysis

- Charges for hemodialysis and peritoneal dialysis.

Durable Medical Equipment (DME) (See Exclusion #5)

- **Short-term Rental:**
  - Rental fees up to the purchase price for items that temporarily assist an impaired person during recovery. Examples include canes, crutches, walkers, hospital beds and wheelchairs.
- **Purchase:**
  - Charges to purchase the equipment. Equipment should be purchased only if it is expected that the rental costs will exceed the purchase price.
- DME exclusions include, but are not limited to:
  - Repairs or replacements due to negligence or loss of the item.
  - Newer or more efficient models.
- DME is eligible for coverage when provided as the most appropriate and lowest cost alternative as required by the person's condition.

NOTE: See Prosthetic Appliances for permanent replacement of a body part.

Emergency Services

The facility in which emergency treatment is rendered and the level of care determines the benefit level (hospital, urgent care center, physician office). For emergency transportation services, refer to the 'Ambulance' section.

- **Emergency Room:**
  - 80% of allowable charges after the special emergency room deductible at a CCHP or non-CCHP facility. The special deductible applies to each visit to an emergency room which does not result in an inpatient admission.
- **Physician's Office:**
  - 80% of allowable charges; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Nonemergency medically necessary care is considered at 60% of allowable charges.
- **Urgent Care or Similar Facility:**
  - 80% of allowable charges; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. This benefit applies to professional fees only. Facility charges not covered when services are performed in a physician's office or urgent care center. Nonemergency medically necessary care is considered at 60% of allowable charges.

Eye Care (See Exclusion #11 and #27)

- Charges for treatment of injury or illness to eye.

Foot Orthotics

Notification is required. Refer to 'Notification Requirements' in the 'College Choice Health Plan' section of the Benefits Handbook for more information.

- Must be custom molded or fit to the foot and ordered by a physician or podiatrist.

Hearing Services

- Professional service charges for the hearing exam associated with the care and treatment of an injury or an illness.

Hospice

- Written notification of the terminal condition is required from the attending physician.
- Inpatient hospice requires notification. Refer to 'Notification Requirements' in the 'College Choice Health Plan' section of the Benefits Handbook for more information.

Inpatient Hospital/Facility Services

(See Exclusions #3, #6, #8, #32)

- Hospital/facility charges.

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Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

NOTE: Failure to provide notification of an upcoming admission or surgery will result in a financial penalty and denial of coverage for services not deemed medically necessary. Refer to 'Notification Requirements' in the 'College Choice Health Plan' section of the Benefits Handbook for more information.

Infertility Treatment

Benefits are provided for the diagnosis and treatment of infertility. Infertility is defined as the inability of opposite sex partners to conceive after one consecutive year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

- Predetermination of Benefits:
  - A written predetermination of benefits must be obtained from the health plan administrator prior to beginning infertility treatment to ensure optimum benefits. Documentation required from the physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy and the proposed plan of treatment with physicians' current procedural terminology (CPT) codes.
- Infertility Benefits:
  - Coverage is provided only if the plan participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this plan.
- Coverage for assisted reproductive procedures include, but is not limited to:
  - Artificial insemination, invitro fertilization (IVF) and similar procedures which include but are not limited to: gamete intrafallopian tube transfer (GIFT), low tube ovum transfer (TET) and uterine embryo lavage.
  - A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime.
  - A maximum of four (4) procedures per lifetime for any of the following: invitro fertilization, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and other similar procedures.
  - If a live birth results from an invitro procedure, two additional procedures are eligible for coverage.
  - Eligible medical costs associated with sperm or egg donation by a person covered under the plan may include, but are not limited to, monitoring the cycle of a donor and retrieval of an egg for the purpose of donating to a covered individual.
  - Retrieval does not count toward the number of maximum attempts.
- Benefit Level:
  - The appropriate benefit level will apply (i.e., physician charges, lab and radiology are covered at 80% for in-network or 60% of allowable charges for out-of-network providers).
- Infertility treatment exclusions include, but are not limited to:
  - Medical or nonmedical costs of anyone NOT covered under the plan.
  - Nonmedical expenses of a sperm or egg donor covered under the plan including, but not limited to transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryopreservation and storage of sperm or embryo or fees payable to a donor.
  - Infertility treatment deemed experimental or unproven in nature.
  - Persons who previously had a voluntary sterilization or persons who are unable to achieve pregnancy after a reversal of a voluntary sterilization.
  - Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy. This exclusion applies whether the surrogate is a plan participant or not.
  - Pre-implantation genetic testing.

Lab and Radiology

- Outpatient:
  - Charges at a physician's office, hospital, clinic or urgent care center.

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Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

- Inpatient:
  - If billed by a hospital as part of a hospital confinement, paid at the appropriate hospital benefit level.
- Professional charges:
  - Professional charges associated with the interpretation of the lab or radiology procedures.

Medical Supplies (See Exclusions #3, #5, #19)

- Medical supplies include, but are not limited to ostomy supplies, surgical dressings and surgical stockings.

Morbid Obesity Treatment (See Exclusion #12)

- Charges for professional services.
- Obesity surgery is eligible for coverage dependent on medical necessity and predetermination of benefits.

Newborn Care (See Exclusion #41)

- Charges for professional services in an office or hospital setting.
- Benefits are available for newborn care only if the dependent is enrolled no later than 31 days following the birth.

Occupational Therapy/Physical Therapy (See Exclusion #10)

Notification is required. Refer to 'Notification Requirements' in the 'College Choice Health Plan' section of the Benefits Handbook for more information.

- Covered if administered under the supervision of and billed by a licensed or registered occupational therapist, physical therapist or physician.

Outpatient Hospital/Facility Services, including Surgery

(See Exclusions #3, #4, #6)

- Covered if performed at a hospital/facility.
- Covered if performed at an ambulatory surgical treatment center which is licensed by the Department of Public Health, or the equivalent agency in other states, to perform outpatient surgery.

Physician Services

- Charges for medical treatment of an injury or illness.

Physician Services – Surgical

(See Exclusions #12, #13, #16)

- Inpatient Surgery:
  - Follow-up care by the surgeon is considered part of the cost of the surgical procedure and is NOT covered as a separate charge.
- Outpatient Surgery:
  - If surgery is performed in a physician's office, the following will be considered as part of the fee:
  - Surgical tray and supplies.
  - Local anesthesia administered by the physician.
  - Medically necessary follow-up visits.
- Plastic and reconstructive surgery is limited for the following:
  - An accidental injury.
  - Congenital deformities evident at infancy.
  - Reconstructive mammoplasty following a mastectomy.
- Assistant surgeon:
  - A payable assistant surgeon is a physician who assists the surgeon, subject to medical necessity.
  - Up to 20% of allowable charges of eligible charges.
- Multiple surgical procedures:
  - Standard plan guidelines are used in processing claims when multiple surgical procedures are performed during the same operative session.
  - Charges for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the plan administrator for a predetermination of benefits.

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Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

Podiatry Services (See Exclusion #9)

Notification is required. Refer to 'Notification Requirements' in the 'College Choice Health Plan' section of the Benefits Handbook for more information.

Prescription Drugs

- Drug charges if billed by a physician's office and not obtained at a pharmacy.
- Prescription drugs obtained as part of a skilled care facility stay are payable by the health plan administrator.
- Prescription drugs obtained as part of a hospital stay are payable at the appropriate facility benefit level.
- Prescription drugs billed by a skilled nursing facility, extended care facility or a nursing home must be submitted to the prescription drug plan administrator.

Preventive Services

Routine preventive care services which do NOT require a diagnosis or treatment are covered at 100% when utilizing a network provider. Out-of-network preventive care is covered at the out-of-network benefit level. Your doctor will determine the tests and frequency that are right for you based on your age, gender and family history. In-network preventive services are not subject to the plan year deductible.

NOTE: Claims which indicate a diagnosis are not considered preventive and are subject to the plan year deductible and coinsurance.

Prosthetic Appliances

A prosthetic appliance is one which replaces a body part. Examples are artificial limbs and artificial eyes.

- Charges for:
  - The original prosthetic appliance.
  - Replacement of a prosthetic appliance due to growth or a change in the person's medical condition.
  - Repair of a prosthetic appliance due to normal wear and usage and no longer functional.
- No payment will be made if the appliance is damaged or lost due to negligence.
- Prosthetic appliances exclusions include, but are not limited to:
  - Appliances not recommended or approved by a physician.
  - Appliances to overcome sexual dysfunction, except when the dysfunction is related to an injury or illness.
  - Items considered cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
  - Experimental or investigational appliances.

Skilled Nursing Service – Home Setting

- Contact the Notification/Medical Case Management plan administrator for a determination of benefits.
- The benefit for skilled nursing service will be limited to the lesser of the cost for care in a home setting or the average cost in a skilled nursing facility, extended care facility or nursing home within the same geographic region.
- The continued coverage for skilled nursing service will be determined by the review of medical records and nursing notes.

Skilled Nursing – In a Skilled Nursing Facility, Extended Care Facility or Nursing Home

(See Exclusions #3, #5, #19)

- Benefits are subject to skilled care criteria and will be allowed for the most cost-effective setting or the level of care required as determined by the Notification/Medical Case Management plan administrator.
- 100 day limit per plan year.
- Must be a licensed healthcare facility primarily engaged in providing skilled care.
- Notification is required at least seven days prior to admission or at time of transfer from an inpatient hospital stay.
- Benefits are limited to the average cost of available facilities within the same geographic region.

In-Network Benefit: Preventive services are paid at 100%. Unless otherwise indicated, a 80% benefit level will be applied to all other eligible services, supplies and therapies.

Out-of-Network Benefit: Unless otherwise indicated, all eligible services, supplies and therapies, including preventive services, are paid at 60% of allowable charges after plan year deductible.

- The service must be medically necessary.
- The continued coverage for skilled nursing service will be determined by the review of medical records and nursing notes.
- Prescription drug charges must be submitted to the health plan administrator.

NOTE: Extended care facilities are sometimes referred to as nursing homes. Most care in nursing homes is NOT skilled care and therefore is NOT covered. Many people purchase long-term care insurance policies to cover those nursing home services which are NOT covered by medical insurance or Medicare.

Speech Therapy

Notification is required. Refer to 'Notification Requirements' in the 'College Choice Health Plan' section of the Benefits Handbook for more information.

- Charges for medically necessary speech therapy ordered by a physician.
- Treatment must be for a speech disorder resulting from injury or illness serious enough to significantly interfere with the ability to communicate at the appropriate age level.
- The therapy must be restorative in nature with the ability to improve communication.
- The person must have the potential for communication.

Transplant Services (Notification Required)

In order for any organ, tissue or bone marrow transplant to be covered under the plan, one of the designated procedure specific transplant hospitals must be utilized. The transplant candidate must contact the Notification/Medical Case Management plan administrator of the potential transplant. Once notification occurs, the Medical Case Manager (MCM) will coordinate all treatments and further notification is not required. Those refusing to participate in the MCM program will be notified that coverage may be terminated under the plan for treatment of the condition.

The transplant benefit includes all diagnostic treatment and related services necessary to assess and evaluate the transplant candidate. All related transplant charges submitted by the transplant hospital are covered at 80% of the contracted rate.

In some cases, transplants may be considered nonviable for some candidates, as determined by the MCM plan administrator in coordination with the transplant hospital.

- Transplant exclusions include, but are not limited to:
  - Investigational drugs, devices or experimental procedures.
  - Charges related to the search for an unrelated bone marrow donor.
  - A corneal transplant is not part of the transplant hospital benefit; however, standard benefits apply under the medical portion of the coverage.

Transplant Coordination of Donor/Recipient Benefits

- When both the donor and the recipient are covered under the plan, both are entitled to benefits under the plan, under separate claims.
- When only the recipient is covered, the donor's charges are covered as part of the recipient's claim if the donor does not have insurance coverage, or if the donor's insurance denies coverage for medical expenses incurred.
- When only the recipient is covered and the donor's insurance provides coverage, the plan will coordinate with the donor's plan.
- When only the donor is covered, only the donor's charges will be covered under the plan.
- When both donor and recipient are members of the same family and are both covered by the plan, no deductible or coinsurance shall apply.

The transplant hospital network is subject to change throughout the year. Call the Notification/Medical Case Management plan administrator for current transplant hospitals.

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Transplant – Transportation and Lodging Benefit

- The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals.
- The plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those plan participants who have been accepted as a candidate for transplant services.
- Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

  Organ Transplant Reimbursement
  DCMS Group Insurance Division
  801 S. 7th Street
  P.O. Box 19208
  Springfield, IL 62794-9208

- The plan participant has twelve months from the date expenses were incurred to submit eligible charges for reimbursement. Requests submitted after the twelve-month limit will not be considered for reimbursement.

Urgent Care Services

Urgent care is care for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a physician's office, urgent care facility or prompt care facility. This benefit applies to professional fees only. If a facility fee is billed, the emergency room deductible applies.

NOTE: See Emergency Services for medically necessary emergency care.

College Choice Health Plan (CCHP) Exclusions and Limitations

No benefits are available:

1. For services or care not recommended, approved and provided by a person who is licensed under the Illinois Medical Practices Act or other similar laws of Illinois, other states, countries or by a nurse midwife who has completed an organized program of study recognized by the American College of Nurse Midwives or by a Christian Science Practitioner.

2. For services and supplies not related to the care and treatment of an injury or illness, unless specifically stated in this document to be a covered service in effect at the time the service was rendered. Excluded services and supplies include, but are not limited to: sports-related health checkups, employer-required checkups, wigs and hairpieces.

3. For care, treatment, services or supplies which are not medically necessary for the diagnosed injury or illness, or for any charges for care, treatment, services or supplies which are deemed unreasonable by the plan.

4. For charges for the services, room and board or supplies that exceed allowable charges.

5. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, nonhospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps, transportation services or any other services or items determined by the plan to be for personal convenience.

6. For rest, convalescence, custodial care or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.

7. For extended care and/or hospital room and board charges for days when the bed has not been occupied by the covered person (holding charges).

8. For private room charges which are not medically necessary as determined by the plan administrator.

9. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia, hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with the diagnosis of diabetes.

10. For chiropractic services, occupational therapy and physical therapy considered to be maintenance in nature, in that medical documentation indicates that maximum medical improvement has been achieved.

11. For keratotomy or other refractive surgeries.

12. For the diagnosis or treatment of obesity, except services for morbid obesity, as approved by the plan administrator.

13. For sexual dysfunction, except when related to an injury or illness.

14. For services relating to the diagnosis, treatment, or appliance for temporomandibular joint disorders or syndromes (TMJ), myofunctional disorders or other orthodontic therapy.

15. For an internal accidental injury to the mouth caused by biting on a foreign object and outpatient services for routine dental care.

16. For the expense of obtaining an abortion, induced miscarriage or induced premature birth, unless it is a physician's opinion that such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the woman or her unborn child.

17. For cosmetic surgery or therapies, except for the repair of accidental injury, for congenital deformities evident in infancy or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.

18. For services rendered by a healthcare provider specializing in behavioral health services who is a candidate in training.

19. For services and supplies which do not meet accepted standards of medical or dental practice at the time the services are rendered.

20. For treatment or services which are investigational, experimental or unproven in nature including, but not limited to, procedures and/or services: which are performed in special settings for research purposes or in a controlled environment; which are being studied for safety, efficacy and effectiveness; which are awaiting endorsement by the appropriate national medical specialty organization; which medical literature does not accept as a reasonable alternative to existing treatments; or, that do not yet meet medical standards of care.

21. For services due to bodily injury or illness arising out of or in the course of a plan participant's employment, which is compensable under any Workers' Compensation or Occupational Disease Act or law.

22. For court mandated services if not a covered service under this plan or not considered to be medically necessary by the appropriate plan administrator.

23. For services or supplies for which a charge would not have been made in the absence of coverage or for services or supplies for which a plan participant is not required to pay.

24. For services arising out of war or an act of war, declared or undeclared, or from participation in a riot, or incurred during or as a result of a plan participant's commission or attempted commission of a felony.

25. For services related to the reversal of sterilization.

26. For lenses (eye glasses or removable contact lenses) except initial pair following cataract surgery.

27. For expenses associated with obtaining, copying or completing any medical or dental reports/records.

28. For services rendered while confined within any federal hospital, except for charges a covered person is legally required to pay, without regard to existing coverage.

29. For charges imposed by immediate relatives of the patient or members of the plan participant's household as defined by the Centers for Medicare and Medicaid Services.

30. For services rendered prior to the effective date of coverage under the plan or subsequent to the date coverage is terminated.

31. For private duty nursing, skilled or unskilled, in a hospital or facility where nursing services are normally provided by staff.

32. For services or care provided by an employer-sponsored health clinic or program.

33. For travel time and related expenses required by a provider.

34. For facility charges when services are performed in a physician's office.

35. For residential treatment for behavioral health services incurred prior to July 1, 2014.

36. For the treatment of educational disorders relating to learning, motor skills, communication and pervasive development conditions.

37. For nonmedical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neuro feedback, hypnosis, sleep therapy, employment counseling, back-to-school, return to work services, work hardening programs, driving safety and services, training, educational therapy or nonmedical ancillary services for learning disabilities, developmental delays, autism (except as provided under covered expenses) or mental retardation.

38. For telephone, email and internet consultations and telemedicine.

39. For expenses associated with legal fees.

40. For medical and hospital care and cost for the infant child of a dependent, unless this infant is otherwise eligible under the plan.

41. For transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to any such surgery.

42. For transportation between healthcare facilities because of patient's choice; transportation of patients who have no other available means of transportation; transportation that is not medically necessary; or Medicar or similar type of transportation when used for patient's convenience.

43. For acupuncture.

Prescription Coverage

Overview

Plan participants enrolled in any College Insurance Program (CIP) health plan have prescription drug benefits included in the coverage. **Regardless of the plan chosen, a prescription copayment applies to each plan participant.** If the cost of the prescription is less than the plan's prescription copayment, the plan participant will pay the cost of the prescription. However, if a plan participant elects a brand name drug and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, in addition to the brand copayment.

Prior authorization may be required for a select group of medications. If a prescription is presented for one of these medications, the pharmacist will indicate that a prior authorization is needed before the prescription can be filled. To receive a prior authorization, the prescribing physician must provide medical information including a diagnosis to the prescription drug plan administrator for review. Once a prior authorization is in place, the prescriptions may be filled until the authorization expires, usually one year.

Plan participants who have additional prescription drug coverage, including Medicare, should contact their prescription plan administrator for coordination of benefits (COB) information.

Formulary List

All prescription medications are compiled on a formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in four levels: generic, preferred brand, nonpreferred brand and specialty. Each level requires a different copayment amount. Each plan maintains a formulary list of medications. Formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of network pharmacies that participate in the various health plans, plan participants should visit the website of their health plan. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

Health Maintenance Organizations (HMOs)

Health maintenance organizations (HMOs) use a separate prescription benefit manager (PBM) to administer their prescription drug benefits. Benefit recipients who elect one of these health plans must utilize a pharmacy participating in the plan's pharmacy network or the full retail cost of the medication will be charged. If a plan participant uses a nonparticipating pharmacy, partial reimbursement may be provided if the plan participant files a claim with the health plan. It should be noted that most plans do not cover over-the-counter drugs or drugs prescribed by medical professionals (including dentists), other than the plan participant's primary care physician (PCP) or any specialist the plan participant was referred to by their PCP. **Members should direct prescription benefit questions to the respective health plan administrator. Refer to the annual Benefit Choice Options booklet for specific information regarding copayment amounts.**

Open Access Managed Care Plans and the College Choice Health Plan (CCHP)

Open access managed care plans and the College Choice Health Plan (CCHP) have prescription drug benefits administered through the self-insurance plans' prescription benefit manager (PBM). Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or out-of-pocket maximums. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. Members enrolled in the CCHP or an open access managed care plan are limited to a 60-day maximum supply per fill. Members may receive a 90-day supply of medication for two copayments by utilizing the mail order option. See the 'Mail Order Prescriptions' section for details.

Prescription Drug Step Therapy (PDST) is required for members who have their prescription drug benefits administered through CCHP or one of the open access managed care plans are subject to a coverage tool called PDST for specific drugs. PDST requires the member to first try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their doctor may have prescribed. PDST is

Prescription Coverage (cont.)

intended to reduce costs to both the member and the plan by encouraging the use of medications that are less expensive but can still treat the member's condition effectively.

Members taking a brand medication that requires step therapy, which has not received prior authorization approval, will receive a rejection at a retail or mail order pharmacy as the plan requires a generic in that drug class be tried first. If the physician believes the original brand medication is needed, he/she may request a review to override the step therapy requirement.

Compound drugs are covered under the prescription drug plan. Compound drugs purchased from a network pharmacy are subject to the non-preferred copayment. If the compound drug contains an ingredient not covered by the plan, the entire compound drug will be denied.

Injectable and intravenous medications may be obtained through a retail network pharmacy or through the prescription drug plan administrator's mail order pharmacy.

If a network pharmacy does not stock a particular drug or supply and is unable to obtain it, call the prescription drug plan administrator for further direction.

Prepackaged prescriptions – A copayment is based on a 1 to 30-day supply as prescribed by the physician. Since manufacturers sometimes prepackage products in amounts that may be more or less than a 30-day supply as prescribed, more than one copayment may be required.

- **Example A** (more than a 30-day supply): Manufacturers commonly prepackage lancets in units of 100. If the 30-day prescription is for 90 units, two copayments are required since the prepackaged amount exceeds the 30-day supply as required by the prescription.
- **Example B** (less than a 30-day supply): Manufacturers commonly prepackage certain supplies, such as inhalers and tubes of ointment. Since the packaged medication may be less than a 30-day supply, more than one packaged unit may be required; therefore, more than one copayment will be required.

Prescribed medical supplies are supplies necessary for the administration of prescription drugs such as covered hypodermic needles and syringes. Copayments may apply.

Diabetic supplies and insulin that are purchased with a prescription are covered through the plan and are subject to the appropriate copayment.

Some diabetic supplies are also covered under Medicare Part B. If the plan participant is not Medicare Part B primary, the appropriate copayment must be paid at the time of purchase at a network pharmacy. If Medicare Part B is primary, the plan participant is responsible for the Medicare coinsurance at the time of purchase. The claim must first be submitted to Medicare for reimbursement. Upon receipt of the Medicare Summary Notice (MSN), a claim may be filed with the prescription drug plan administrator for any secondary benefit due. If the diabetic supplies are billed by a physician or medical supplier, the supplies would be paid by the health plan administrator.

Insulin pumps and their related supplies are not covered under the prescription drug plan. In order to receive coverage for these items, contact the health plan administrator listed in the current Benefit Choice Options booklet.

Mail Order Prescriptions

The mail order pharmacy option provides participants the opportunity to receive medications directly from the PBM. Both maintenance and nonmaintenance medications may be obtained through the mail order process. When plan participants use the mail order pharmacy for maintenance medications they will receive a **90-day supply of medication (equivalent to 3 fills) for only two copayments.** To utilize the mail order pharmacy, plan participants must submit an original prescription from the attending physician. For maintenance medication, the prescription should be written for a 90-day supply and include up to three 90-day refills totaling one year of medication. The original prescription must be attached to a completed Mail Order form and sent to the address indicated on the form. Order forms can be obtained by contacting the PBM or by accessing the Benefits website.

Coordination of Benefits

CIP coordinates with Medicare and other group plans. The appropriate copayment will be applied for each prescription filled.

Exclusions and Limitations

CIP reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

Behavioral Health

Overview

Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders. Eligible charges are for those covered services deemed medically necessary by the plan administrator. The coverage of behavioral health services (mental health and substance abuse) complies with the federal Mental Health Parity and Addiction Equity Act of 2008. This federal law requires health plans to cover behavioral health services at benefit levels equal to those of the plan's medical benefits.

Coverage for behavioral health services is provided under all of the CIP plans. There are no restrictions regarding the number of visits and hospital days allowed per plan year. The charges for behavioral health services are included in a plan participant's annual plan deductible if applicable and annual out-of-pocket maximum. Covered services for behavioral health must still meet the plan administrator's medical necessity criteria and will be paid in accordance with the benefit schedule. Please contact the health plan for specific benefit information.

College Choice Health Plan (CCHP)

Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the College Choice Health Plan (CCHP) benefit schedule for in-network and out-of-network providers. Please contact the behavioral health plan administrator for specific benefit information and for a listing of in-network hospital facilities and participating providers.

Authorization Requirements for Behavioral Health Services

In an emergency or a life-threatening situation, call 911, or go to the nearest hospital emergency room. Plan participants must call the behavioral health plan administrator within 48 hours to avoid a financial penalty. Authorization requirements still apply when plan participants have other coverage, such as Medicare.

- **Inpatient services** must be authorized prior to admission or within 48 hours of an emergency admission to receive in-network or out-of-network benefits. Authorization is required with each new admission. Failure to notify the behavioral health plan administrator of an admission to an inpatient facility within 48 hours will result in a financial penalty and risk incurring noncovered charges.
- **Partial hospitalization and intensive outpatient treatment** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required before beginning each treatment program. Failure to notify the behavioral health plan administrator of a partial hospitalization or intensive outpatient program will result in a financial penalty and risk incurring noncovered charges.
- **Outpatient services** received at the in-network benefit level must be provided by a CCHP network provider. Most routine outpatient services (such as therapy sessions and medication management) will be covered without the need for prior authorization. Authorization requirements for certain specialty outpatient services are noted below. Outpatient services that are not consistent with usual treatment practice for a plan participant's condition will be subject to a medical necessity review. The behavioral health administrator will contact the plan participant's provider to discuss the treatment if a review will be applied. Outpatient services received at the out-of-network benefit level must be provided by a licensed professional including licensed clinical social worker (LCSW), registered nurse, clinical nurse specialist (RN CNS), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), psychologist or psychiatrist to be eligible for coverage.
- **Electroconvulsive therapy, psychological testing and applied behavioral analysis** must be authorized to receive in-network or out-of-network benefits. Failure to obtain authorization will result in the risk of incurring noncovered charges.
- **Residential services** must be authorized prior to admission to receive in-network or out-of-network benefits. Authorization is required with each new residential admission. Failure to notify the behavioral health plan administrator of an admission to a residential facility will result in a financial penalty and risk incurring noncovered charges.

Dental Coverage

Overview

The College Choice Dental Plan (CCDP) is designed to offer plan participants coverage for basic dental services regardless of the health plan chosen.

Each plan participant is subject to an **annual dental plan deductible** for all dental services, except those listed in the Dental Schedule of Benefits as 'Diagnostic' or 'Preventive'. Once the deductible has been met, the plan participant is subject to a maximum annual dental benefit. See the current Benefit Choice Options booklet for the amount of the maximum benefit.

- Plan participants may go to any dentist.
- The maximum benefit amount paid for eligible services is listed in the Dental Schedule of Benefits. Dental procedure codes that are not listed in the Dental Schedule of Benefits are not covered by the plan and are not eligible for payment. Members are responsible for all charges over the scheduled amount and/or over the annual maximum benefit. The Dental Schedule of Benefits is available on the Benefits website at **www.benefitschoice.il.gov.**
- Plan participants may obtain dental identification cards from the dental plan administrator.

Choosing a Provider

With CCDP, plan participants can choose any dental provider for services; however, plan participants will receive enhanced benefits, resulting in lower out-of-pocket costs, when they receive services from a network provider. There are two separate networks of providers that a plan participant may utilize for dental services: the PPO network and the Premier network.

- **PPO Network:** If you receive services from a PPO dentist, your out-of-pocket expenses will often be less because these providers accept a reduced PPO fee (less any deductible). If the PPO fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.
- **Premier Network:** If you receive services from a Premier dentist, your out-of-pocket expenses may be less because Premier providers accept the allowed Premier fee (less any deductible). If the allowed fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.

Out-of-Network Services

If you receive services from a dentist who does not participate in either the PPO or Premier network, the amount paid by the plan will be in accordance with the Schedule of Benefits.

Preventive and Diagnostic Services

Preventive and diagnostic services are not subject to the annual deductible and include, but are not limited to:

- Two periodic oral examinations per person per plan year.
- Two adult or child prophylaxis (scaling and polishing of teeth) per person per plan year.
- Two bitewing radiographs per person per plan year.
- One full mouth radiograph per person every three plan years.

Prosthodontics

Prosthodontics, which include crowns, bridges and dentures, are subject to the following limitations:

- Prosthodontics to replace missing teeth are covered **only for teeth that are lost while the person is covered under this plan**.
- Immediate dentures are covered only if five or more teeth are extracted on the same day.
- Permanent dentures to replace immediate dentures are covered only if placed in the person's mouth within two years from the placement of the immediate denture.
- Replacement dentures are covered only under one of the following circumstances:
  - Existing denture is at least 5 years old, or
  - Structural changes in the person's mouth require new dentures.
- Replacement crowns are covered only when the existing crown is at least 5 years old.
- Replacement bridges are covered only when the existing bridge is at least 5 years old.

Dental Coverage (cont.)

Child Orthodontics

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. A maximum lifetime benefit for child orthodontia applies regardless of the number of courses of treatment. The annual plan year deductible will need to be satisfied unless it was previously satisfied for other dental services incurred during the plan year.

The maximum lifetime benefit amount applies to each plan participant and does not start over with each course of treatment. A course of treatment can be for any orthodontic services, not only the placement of braces. For example, a child may have a retaining device when they are 8 years old and then have braces installed when they are 15. The benefit amount for the retainer plus the benefit amount for the braces can not exceed the maximum lifetime benefit amount allowed.

The benefit amount that will be paid for orthodontic treatment depends on the length of treatment plan as determined by the orthodontist. The length of treatment time frames and the associated benefit amount allowed is listed in the annual Benefit Choice Options booklet.

Twenty-five percent (25%) of the applicable orthodontia benefit, based on the length of treatment, will be reimbursed after the initial banding. The remaining benefit will be prorated over the remaining length of treatment period.

Provider Payment

If you use a network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit). Network dentists will automatically file the dental claim for their patients. Members who use a network provider and do not have any out-of-pocket costs for their visit will not receive an explanation of benefits (EOB). The member may, however, view their EOB on the dental plan administrator's website.

Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist. Out-of-network dentists can elect to accept assignment from the plan or may require other payment terms. Coordination of benefits applies to any other dental coverage.

Pretreatment Estimate

For both prosthodontics and orthodontics, although not required, a pretreatment estimate is strongly encouraged to assist plan participants in determining the benefits available. To obtain a pretreatment estimate plan participants should contact their dental provider.

Benefits for Services Received While Outside the United States

The plan covers eligible charges incurred for services received outside of the United States. All plan benefits are subject to plan provisions and deductibles.

Payment for the services may be required at the time service is provided and a paper claim must be filed with the dental plan administrator. When filing the claim, enclose the itemized bill with a description of the service translated to English and converted to U.S. currency along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.

Dental Coverage (cont.)

Dental Exclusions and Limitations

No benefits shall be payable for:

1. Dental services covered under the health plan.
2. Services rendered prior to the plan participant's effective date of coverage or subsequent to the date of termination of coverage.
3. Services not listed in this plan description or for services rendered prior to the date a service or procedure became a covered benefit as indicated in this plan description.
4. Services performed to correct congenital and /or developmental conditions including but not limited to malformations, retention of deciduous (baby) teeth, impaction or absence of permanent teeth, cleft palate, mandibular prognathism or retrognathism, enamel hypoplasia, amelogenesis imperfecta, fluorosis, and anodontia (i.e., the absence of teeth) are excluded from coverage.
5. Dental services relating to the diagnosis or treatment, including appliances, for temporomandibular joint disorders (TMJ) and myofunctional disorders, craniofacial pain disorders and orthognathic surgery. However, occlusal guards are covered.
6. Services not necessary or not consistent with the diagnosis or treatment of a dental condition, as determined by the dental plan administrator.
7. Orthodontia of deciduous (baby) teeth or adult orthodontia.
8. Services compensable under the Workers' Compensation Act or Employer's Liability Law.
9. Procedures or surgeries undertaken for primarily cosmetic reasons.
10. Construction of duplicate dentures.
11. Replacement of a fixed or removable prosthesis for which benefits were paid under this plan for the same tooth/teeth, if the replacement occurs within five years from the date the expense was incurred, unless:
    - The prosthesis is a stayplate or a similar temporary prosthesis and is being replaced by a permanent prosthesis; or
    - The prosthesis, while in the oral cavity, has been damaged beyond repair, as a result of injury while eligible under the plan.
12. Customization of dental prosthesis, including personalized, elaborate dentures or specialized techniques.
13. Expenses associated with obtaining, copying or completing any dental or medical reports.
14. Charges for procedures considered experimental in nature.
15. Service or care performed by a family member or other person normally residing with the participant.
16. Services provided or paid for by a governmental agency or under any governmental program or law, except for charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its amendments.
17. General anesthesia, conscious sedation and intravenous sedation services (with the exception of children under age 6) unless medically necessary. Supporting documentation from a physician will be reviewed by the dental plan administrator.
18. Fixed or removable prosthodontics for a patient under age 18 is not a covered benefit.
19. Sealants applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for dependent children under age 18.
20. Amalgam and resin-based composite fillings once per surface in a 12-month interval.

Vision Coverage

Overview

The vision plan is designed to assist with the costs of well-vision care and to encourage the maintenance of vision through regular eye exams. Periodic eye exams can detect and prevent ailments not only in the eyes, but throughout the body. The plan provides coverage when glasses or contacts are required. For more information, contact the vision plan administrator.

Eligibility

All plan participants covered by any of the health plans offered by the College Insurance Program are eligible for vision care benefits. Benefit levels are published on an annual basis in the Benefit Choice Options booklet.

Frequency of Benefits

Each service component is available once every 24 months from the last time the benefit component was used. Each service component is independent and may be obtained at separate times from separate providers. For example, a plan participant may receive an eye examination from one provider and purchase frames/lenses from a different provider.

Provider Services

Materials and services obtained from a network provider are paid at the network provider coverage benefit level. Applicable copayments and additional charges must be paid at the time of service. Eligible services or materials may be obtained from any licensed optometrist, ophthalmologist or optician. A directory of network providers can be found on the plan administrator's website.

If an out-of-network provider is used, the plan participant must pay the provider in full and request reimbursement from the vision plan administrator. To request reimbursement, send an itemized receipt and a claim form requesting reimbursement to the vision plan administrator. Reimbursement will be paid up to the maximum allowance amount as detailed in the schedule of benefits, out-of-network provider coverage chart in the annual Benefit Choice Options booklet. Out-of-network provider benefits are paid directly to the covered member. Claim forms are available on the Benefits website and through the plan administrator.

Chapter 3

Chapter 3: Miscellaneous

Coordination of Benefits

If a plan participant enrolled in the College Insurance Program (CIP) is entitled to primary benefits under another group plan, the amount of benefits payable under CIP may be reduced. The reduction may be to the extent that the total payment provided by all plans does not exceed the total allowable expense incurred for the service. Allowable expense is defined as a medically necessary service for which part of the cost is eligible for payment by this plan or one of the plans identified below.

Under coordination of benefits (COB) rules, CIP's plan first calculates what the benefit would have been for the claim if there was no other plan involved. The CIP plan then considers the amount paid by the primary plan and pays the claim up to 100% of the allowable expense.

NOTE: When a managed care health plan is the secondary plan and the plan participant does not utilize the managed care health plan's network of providers or does not obtain the required referrals, the managed care health plan is not required to pay. Refer to the managed care plan's summary plan document for additional information.

CIP coordinates benefits with the following:

- Any group insurance plan.
- Medicare.
- Any Veterans' Administration (VA) plan.
- Any "no-fault" motor vehicle plan. This term means a motor vehicle plan which is required by law and provides medical or dental care payments which are made, in whole or in part, without regard to fault. A person who has not complied with the law will be deemed to have received the benefits required by the law.

CIP does not coordinate benefits with the following:

- Private individual insurance plans.
- Any student insurance policy (elementary, high school and college).
- Medicaid or any other State-sponsored health insurance program.
- TRICARE.

It is the member's responsibility to provide other insurance information (including Medicare) to the Medicare Coordination of Benefits (COB) Unit. Any changes to other insurance coverage must be reported promptly to the Medicare COB Unit.

Order of Benefit Determination

CIP's medical and dental plans follow the National Association of Insurance Commissioners (NAIC) model regulations. These regulations dictate the order of benefit determination, except for members who are eligible for Medicare due to End-Stage Renal Disease (ESRD). Refer to the 'Medicare' section for details regarding coordination of benefits for plan participants eligible for Medicare. **The rules below are applied in sequence.** If the first rule does not apply, the sequence is followed until the appropriate rule that applies is found. Special rules apply for children of civil union partners. Contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007 for more information.

Member

The plan that covers the plan participant as an active member is primary:

1. Over the plan that covers the plan participant as a dependent.
2. Over the plan that covers the plan participant as a retiree.
3. Over the plan that covers the plan participant under COBRA.
4. If it has been in effect the longest, back to the original effective date under the employer group, whether or not the insurance company has changed over the course of coverage.

Dependent Children of Parents Not Separated or Divorced

The following "Birthday Rule" is used if a child is covered by more than one group plan. The plans must pay in the following order:

1. The plan covering the parent whose birthday* falls earlier in the calendar year is the primary plan.
2. If both parents have the same birthday, the plan that has provided coverage longer is the primary plan.

** Birthday refers only to the month and day in a calendar year, not the year in which the person was born.*

NOTE: Some plans not covered by state law may follow the Gender Rule for dependent children. This rule states that the father's coverage is the primary carrier. In the event of a disagreement between two plans, the Gender Rule applies.

Coordination of Benefits (cont.)

Dependent Children of Separated or Divorced Parents

If a child is covered by more than one group plan and the parents are separated or divorced, the plans must pay in the following order:

1. The plan of the parent with custody of the child;
2. The plan of the spouse of the parent with custody of the child;
3. The plan of the parent not having custody of the child.

NOTE: If the terms of a court order state that one parent is responsible for the healthcare expenses of the child and the health plan has been advised of the responsibility, that plan is primary payer over the plan of the other parent.

Dependent Children of Parents with Joint Custody

The Birthday Rule applies to dependent children of parents with joint custody.

Medicare

Overview

Medicare is a federal health insurance program for individuals age 65 and older, individuals under age 65 with certain disabilities and individuals of any age with End-Stage Renal Disease (ESRD). If you do not enroll in Parts A and B, you will be responsible for the portion of your healthcare costs that Medicare would have covered.

The Social Security Administration (SSA) or the Railroad Retirement Board (RRB)** determines Medicare eligibility upon application and enrolls eligible plan participants into the Medicare Program. The Medicare Program is administered by the Centers for Medicare and Medicaid Services (also known as the federal CMS).

Medicare has the following parts:

- **Part A** is insurance that helps pay for inpatient hospital facility charges, skilled nursing facility charges, hospice care and some home healthcare services. Medicare Part A does not require a monthly premium contribution from plan participants with enough earned work credits. Plan participants without enough earned work credits have the option to enroll in Medicare Part A and pay a monthly premium contribution.
- **Part B** is insurance that helps pay for outpatient services including physician office visits, labs, x-rays and some medical supplies. Medicare Part B requires a monthly premium contribution.
- **Part C** (also known as Medicare Advantage) is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D. An individual must already be enrolled in Medicare Parts A and B in order to enroll in a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Part D** is insurance that helps pay for prescription drugs. Generally, Medicare Part D requires a monthly premium contribution.

Medicare Due to Age

Plan Participants Age 65 and older

CIP requires all plan participants to contact the SSA and apply for Medicare benefits three months prior to turning age 65.

Medicare Part A

Eligibility for premium-free Medicare Part A occurs when an individual is age 65 or older and has earned at least 40 work credits from paying into Medicare through Social Security. An individual who is not eligible for premium-free Medicare Part A benefits based on his/her own work credits may qualify for premium-free Medicare Part A benefits based on the work history of a current, former or deceased spouse. All plan participants that are determined to be ineligible for Medicare Part A based on their own work history are required to apply for premium-free Medicare Part A on the basis of a spouse (when applicable).

If the SSA determines that a plan participant is eligible for premium-free Medicare Part A, **CIP requires that the plan participant accept the Medicare Part A coverage** and submit a copy of the Medicare identification card to the Medicare COB Unit upon receipt.

If the SSA determines that a plan participant is not eligible for Medicare Part A benefits at a premium-free rate, CIP does not require the plan participant to purchase Medicare Part A coverage; however, CIP does require the plan participant to provide a written statement from the SSA advising of his/her Medicare Part A ineligibility. The plan participant is required to submit a copy of the SSA statement to the Medicare COB Unit.

Medicare Part B

Most plan participants are eligible for Medicare Part B upon turning the age of 65.

In order to apply for Medicare benefits, plan participants should contact the local SSA office or call the SSA at (800) 772-1213. Plan participants may enroll in Medicare Part A on the SSA website at www.socialsecurity.gov.

****Railroad Retirement Board (RRB) participants should contact their local RRB office or call the RRB at (877) 772-5772 to apply for Medicare.**

Medicare (cont.)

CIP requires plan participants to enroll in Medicare Part B if they are eligible for Medicare Part A benefits at a premium-free rate. Refer to the 'Medicare Part B Reduction' section for more information.

Medicare Due to Disability

Plan Participants Age 64 and Under

Plan participants are automatically eligible for Medicare (Parts A and B) disability insurance after receiving Social Security disability payments for a period of 24 months.

Medicare Part A

Plan participants who become eligible for Medicare disability benefits are **required** to accept the Medicare Part A coverage and submit a copy of the Medicare identification card to the Medicare COB Unit upon receipt.

Medicare Part B

Plan participants who become eligible for Medicare disability benefits are **required** to accept the Medicare Part B coverage. Refer to the 'Medicare Part B Reduction' section for more information.

Medicare Due to End-Stage Renal Disease (ESRD)

All CIP participants who are receiving regular dialysis treatments or who have had a kidney transplant on the basis of ESRD are required to apply for Medicare benefits.

Plan participants must contact the State of Illinois Medicare Coordination of Benefits (COB) Unit at (800) 442-1300. The State of Illinois Medicare COB Unit calculates the 30-month coordination period in order for plan participants to sign up for Medicare benefits on time to avoid additional out-of-pocket expenditures.

Medicare Part A

Plan participants who become eligible for Medicare benefits on the basis of ESRD are **required** to accept the Medicare Part A coverage and submit a copy of the Medicare identification card to the Medicare COB Unit upon receipt.

Medicare Part B

CIP requires plan participants to enroll in Medicare Part B if they are eligible for Medicare Part A benefits at a premium-free rate. Plan participants who become eligible for Medicare benefits on the basis of ESRD are required to accept the Medicare Part B coverage when Medicare is determined to be the primary payer. Refer to the 'Medicare Part B Reduction' section for more information.

Medicare Coordination with the College Choice Health Plan (CCHP)

When Medicare is the primary payer, CCHP will coordinate benefits with Medicare as follows:

Medicare Part A - Hospital Insurance

In-Network Provider: After Medicare Part A pays, CCHP pays 80% of the Medicare Part A deductible after the CCHP annual plan deductible has been met.

Out-of-Network Provider: After Medicare Part A pays, CCHP pays 60% of the Medicare Part A deductible after the CCHP annual plan deductible has been met.

Medicare Part B - Medical Insurance

In-Network Provider: After Medicare Part B pays, CCHP pays 80% of the balance after the CCHP annual plan deductible has been met.

Out-of-Network Provider: After Medicare Part B pays, CCHP pays 60% of the balance after the CCHP annual plan deductible has been met.

Failure to Enroll in Medicare (Medicare Parts A and B Reduction)

If you do not enroll in Parts A and B, you will be responsible for the portion of your healthcare costs that Medicare would have covered. Failure to enroll or remain enrolled in Medicare when Medicare is determined to be the primary payer over the CCHP will result in a reduction of eligible benefit payments by the CCHP plan. For in-network provider claims, CCHP will estimate the portion of the claim that Medicare would have paid. CCHP will then pay 80%

Medicare (cont.)

of the 20% claim balance (after the annual plan year deductible has been satisfied). For out-of-network provider claims, CCHP will pay 60% of the 20% of the claim balance (after the CCHP plan year deductible has been satisfied). The difference between the total charge and the amount CCHP pays is the plan participant's responsibility.

Services and Supplies Not Covered by Medicare

Services and supplies that are not covered by Medicare will be paid by CCHP in the same manner (i.e., same benefit levels and deductibles) as if the plan participant did not have Medicare (provided the services and supplies meet medical necessity and benefit criteria and would normally be eligible for CCHP coverage).

Medicare Crossover

Medicare crossover is an electronic transmittal of claim data from Medicare (after Medicare has processed their portion of the claim) to the CCHP plan administrator for secondary benefits.

In order to set up Medicare Crossover, plan participants must contact the CCHP plan administrator and provide the Medicare Health Insurance Claim Number (HICN) located on the front side of their Medicare identification card.

Medicare COB Unit Contact Information

Department of Central Management Services
Medicare Coordination of Benefits Unit
801 S. 7th Street, P.O. Box 19208
Springfield, Illinois 62794-9208

Phone: (800) 442-1300 or (217) 782-7007
Fax: (217) 557-3973

Private Contracts with Providers who Opt Out of Medicare

Some healthcare providers choose to opt out of the Medicare program. When a plan participant has medical services rendered by a provider who has opted out of the Medicare program, a private contract is usually signed explaining that the plan participant is responsible for the cost of the medical services rendered. Neither providers nor plan participants are allowed to bill Medicare. Therefore, Medicare will not pay for the service (even if it would normally qualify as being Medicare eligible) or provide a Medicare Summary Notice to the plan participant. If the service(s) would have normally been covered by Medicare, the CCHP plan administrator will estimate the portion of the claim that Medicare Part B would have paid. The CCHP plan administrator will then pay 80% of the 20% claim balance (after the annual plan year deductible has been satisfied) for services rendered by in-network CCHP providers. For out-of-network CCHP provider claims, CCHP will pay 60% of the 20% (after the CCHP plan year deductible has been satisfied). The difference between the total charge and what CCHP pays is the plan participant's responsibility.

Subrogation and Reimbursement

Overview

Department plans will not pay for expenses incurred for injuries received as the result of an accident or incident for which a third party is liable. These plans also do not provide benefits to the extent that there is other coverage under nongroup medical payments (including automobile liability) or medical expense type coverage to the extent of that coverage.

However, the plans will provide benefits otherwise payable under one of these plans, to or on behalf of its covered persons, but only on the following terms and conditions:

- In the event of any payment under one of these plans, the plan shall be subrogated to all of the covered person's rights of recovery against any person or entity. The covered person shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The covered person shall do nothing after loss to prejudice such rights. The covered person shall cooperate with the plan and/or any representatives of the plan in completing such documents and in providing such information relating to any accident as the plan by its representatives may deem necessary to fully investigate the incident. The plan reserves the right to withhold or delay payment of any benefits otherwise payable until all executed documents required by this provision have been received from the covered person.
- The plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by or on behalf of the covered person. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits paid by the plan.
- The plan, by payment of any proceeds to a covered person, is thereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to or received by or on behalf of the covered person or a representative. The covered person in consideration for such payment of proceeds, consents to said lien and shall take whatever steps are necessary to help the plan secure said lien.
- The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the covered person as a result of the injuries sustained, including but not limited to the following:
  - Payments made directly by a third party tortfeasor or any insurance company on behalf of a third party tortfeasor or any other payments on behalf of a third party tortfeasor.
  - Any payments or settlements or judgments or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a covered person or other person.
  - Any other payments from any source designed or intended to compensate a covered person for injuries sustained as the result of negligence or alleged negligence of a third party.
  - Any Workers' Compensation award or settlement.
- The parents of any minor covered person understand and agree that the State's plan does not pay for expenses incurred for injuries received as a result of an accident or incident for which a third party is liable. Any benefits paid on behalf of a minor covered person are conditional upon the plan's express right of reimbursement. No adult covered person hereunder may assign any rights that such person may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of the adult covered person without the express prior written consent of the plan. In the event any minor covered child is injured as a result of the acts or omissions of any third party, the adult covered persons/parents agree to promptly notify the plan of the existence of any claim on behalf of the minor child against the third party tortfeasor responsible for the injuries. Further, the adult covered persons/parents agree, prior to the commencement of any claim against the third party tortfeasors responsible for the injuries to the minor child, to either assign any right to collect medical expenses from any tortfeasor or other person or entity to the plan, or at their election, to prosecute a claim for medical expenses on behalf of the plan.

Subrogation and Reimbursement (cont.)

In default of any obligation hereunder by the adult covered persons/parents, the plan is entitled to recover the conditional benefits advanced plus costs (including reasonable attorneys' fees), from the adult covered persons/parents.

- No covered person shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by a covered person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to nonmedical expense damages.
- No covered person under the plan shall incur any expenses on behalf of the plan in pursuit of the plan's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits paid hereunder without regard to any claim of fault on the part of any covered person, whether under comparative negligence or otherwise.
- The benefits under this plan are secondary to any coverage under no-fault, medical payments or similar insurance.
- This subrogation and reimbursement provision shall be governed by the laws of the State of Illinois.
- In the event that a covered person shall fail or refuse to honor its obligations hereunder, the plan shall have a right to suspend the covered person's eligibility and be entitled to offset the reimbursement obligation against any entitlement for future medical benefits, regardless of how those medical benefits are incurred. The suspension and offset shall continue until such time as the covered person has fully complied with his obligations hereunder.

Claim Filing

In general, most dental, medical and behavioral health providers file claims for reimbursement with the insurance carrier. Out-of-network vision claims and pharmacy expenses typically must be filed by the member. In situations where a claim is not filed by the provider, the member must file the claim within a specific period of time.

All claims should be filed promptly. Claim forms are available on the plan administrators' website and on the Benefits website.

- In-network **CCHP** medical and behavioral health claims must be filed within 90 days from the date in which the charge was incurred.
- Out-of-network **CCHP** medical and behavioral health claims must be filed within 180 days from the date in which the charge was incurred.
- Out-of-network **dental claims** must be filed no later than one-year from the ending date of the plan year in which the charge was incurred.
- Out-of-network **pharmacy claims for the open access plans (OAPs) and CCHP** must be filed no later than one-year from the ending date of the plan year in which the charge was incurred.
- Out-of-network **vision claims** are required to be filed no later than one year from the date of service in order to be considered for reimbursement.

Filing deadlines for managed care plans, including behavioral health services offered under the managed care plan, may be different. Contact the managed care plan directly for deadlines and procedures.

Claim Filing Procedures

All communication to the plan administrators must include the benefit recipient's social security number (SSN) and appropriate group number as listed on the identification card. This information must be included on every page of correspondence.

- Complete the claim form obtained from the appropriate plan administrator.
- Attach the itemized bill from the provider of services to the claim form. The itemized bill must include name of patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.
- If the person for whom the claim is being submitted has primary coverage under another group plan or Medicare, the explanation of benefits (EOB) or Medicare Summary Notice (MSN) from the other plan must also be attached to the claim.
- The plan administrator may communicate directly with the plan participant or the provider of services regarding any additional information that may be needed to process a claim.
- The benefit check will be sent and made payable to the member (not to any dependents), unless otherwise indicated by law, or benefits have been assigned directly to the provider of service.
- If benefits are assigned, the benefit check will be made payable to the provider of service and mailed directly to the provider. An EOB is sent to the plan participant to verify the benefit determination.
- CCHP claims are adjudicated using industry standard claim processing software and criteria. Claims are reviewed for possible bundling and unbundling of services and charges.

Claim Appeal Process

Under the College Insurance Program there are formal procedures to follow in order to file an appeal of an adverse benefit determination. **The appropriate plan administrator will provide more information regarding the plan administrator's internal appeal process.**

Categories of Appeal

There are two separate categories of appeals: medical and administrative. The plan administrator determines the category of appeal and will send the plan participant written notification regarding the category of appeal, the plan participant's appeal rights and information regarding how to initiate an appeal from the plan administrator.

- **Medical Appeals.** Medical appeals pertain to benefit determinations involving medical judgment, including claim denials determined by the plan administrator to be based on lack of medical necessity, appropriateness, healthcare setting, level of care or effectiveness; denials pursuant to Section 6.4 of the State Employees Group Insurance Act; and denials for services determined by the plan administrator to be experimental or investigational. Medical appeals also pertain to retroactive cancellations or discontinuations of coverage, unless the cancellation or discontinuation relates to a failure to pay required premiums or contributions.
- **Administrative Appeals.** Administrative appeals pertain to benefit determinations based on plan design and/or contractual or legal interpretations of plan terms that do not involve any use of medical judgment.

College Choice Health Plan (CCHP) and Open Access Managed Care Plans Appeal Process

Members enrolled in either the College Choice Health Plan (CCHP) or one of open access managed care plans may utilize an internal appeal process which may be followed by an external review, if needed. For urgent care situations, the plan participant may bypass the internal appeal process and request an expedited external review (see "Expedited External Review- Medical Appeals Only" for urgent care situations in the box).

Expedited External Review - Medical Appeals Only

For medical appeals involving urgent care situations, the plan participant may make a written or oral request for expedited external review after the plan administrator makes an adverse benefit determination, even if the plan administrator's internal appeal process has not been exhausted. The external reviewer will review the request to determine whether it qualifies for expedited review. If the external reviewer determines that the request qualifies for expedited review, the external reviewer will provide a final external review decision within 72 hours after the receipt of the request. If the external reviewer decides in favor of the plan participant, the decision shall be final and binding on the plan administrator.

Step 1: Internal Appeal Process

The internal appeal process is available through the health plan administrator. The plan administrator's internal appeal process must be followed before the plan participant may seek an external review, except for urgent care situations. For urgent care situations, the plan participant may request an expedited external review (see "Expedited External Review- Medical Appeals Only" for urgent care situations).

First-Level Internal Appeals

First-level appeals must be initiated with the plan administrator within 180 days of the date of receipt of the initial adverse benefit determination. All appeals will be reviewed and decided by an individual(s) who was not involved in the initial claim decision. Each case will be reviewed and considered on its own merits. If the appeal involves a medical judgment, it will be reviewed and considered by a qualified healthcare professional. In some cases, additional information, such as test results, may be required to determine if additional benefits are available. Once all required information has been received by the plan administrator, the plan administrator shall provide a decision within the applicable time frame: 15 days for pre-service authorizations, 30 days for post-service claims, or 72 hours for urgent care claims.

Claim Appeal Process (cont.)

Step 2: External Review Process

After the completion of the plan administrator's internal appeal process, the plan participant may request an external review of the plan administrator's final internal benefit determination. The process for external review will depend on whether the appeal is an administrative appeal or medical appeal.

Administrative Appeals

For administrative appeals, if, after exhausting every level of review available through the plan administrator, the plan participant still feels that the final benefit determination by the plan administrator is not consistent with the published benefit coverage, the plan participant may appeal the plan administrator's decision to CMS' Group Insurance Division. For an appeal to be considered by CMS' Group Insurance Division, the plan participant must appeal in writing within sixty (60) days of the date of receipt of the plan administrator's final internal adverse benefit determination. All appeals must be accompanied by all documentation supporting the request for reconsideration.

Submit Administrative Appeal Documentation to:

CMS Group Insurance Division
801 S. 7th Street
P.O. Box 19208
Springfield, IL 62794-9208

The decision of CMS' Group Insurance Division shall be final and binding on all parties.

Medical Appeals
External Review

For medical appeals, if, after exhausting every level of review available through the plan administrator, the plan participant still feels that the final benefit determination is not consistent with the published benefit coverage, the plan participant may request an independent external review of the plan administrator's decision. A request for an external review must be filed in writing within four (4) months of the date of receipt of the plan administrator's final internal adverse benefit determination. The plan administrator will provide more information regarding how to file a request for external review. The plan participant will be given the opportunity to submit additional written comments and supporting medical documentation regarding the claim to the external reviewer. The external reviewer will provide a final external review decision within 45 days of the receipt of the request. If the external reviewer decides in favor of the plan participant, the decision shall be final and binding.

Appeal Process for Fully-Insured Managed Care Health Plans

The Department of Central Management Services (CMS) does not have the authority to review or process fully-insured managed care health plan appeals. Fully-insured managed care health plans must comply with the Managed Care Reform and Patient Rights Act. In order to file a formal appeal, refer to the process outlined in the managed care health plan's summary plan document (SPD) or certificate of coverage. Specific timetables and procedures apply. Plan participants may call the customer service number listed on their identification card to request a copy of such documents.

Assistance with the Appeal Process

For questions regarding appeal rights and/or assistance with the appeal process, a plan participant may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). A consumer assistance program may also be able to assist the plan participant. Requests for assistance from the consumer assistance program should be sent to:

Office of Consumer Health Insurance
Consumer Services Section
122 S. Michigan Ave., 19th FL
Chicago, IL 60603
www.insurance.illinois.gov
(877) 527-9431
Email: doi.director@illinois.gov
or

Illinois Department of Insurance
320 W. Washington St, 4th Floor
Springfield, IL 62727

Chapter 4

Chapter 4: Reference

Glossary

Additional Deductible: Deductibles that are in addition to the annual plan deductible.

Admission: Entry as an inpatient to an accredited facility, such as a hospital or skilled care facility, or entry to a structured outpatient, intensive outpatient or partial hospitalization program.

Adverse Claim Determination: A denial, reduction, termination of or failure to pay for a benefit, whether in whole or in part. Adverse claim determinations include rescissions of coverage.

Allowable Charges: The maximum amount the plan will pay an out-of-network healthcare professional for billed services.

Allowable Expense: A medically necessary service for which part of the cost is eligible for payment by this plan or another plan(s).

Authorization: The result of a review that approves treatment as meeting medical necessity criteria and appropriateness of care.

Benefit: The amount payable for services obtained by plan participants and dependents.

Benefit Choice Period: A designated period when members may change benefit coverage elections, ordinarily held May 1 through May 31.

Benefit Recipient: An annuitant or survivor enrolled in the College Insurance Program.

Certificate of Coverage: A document containing a description of benefits provided by licensed insurance plans. Also known as a summary plan description (SPD).

Certificate of Creditable Coverage: A certificate that provides evidence of prior health coverage.

Civil Union: Civil union means a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Civil Union Partner: A party to a civil union.

Claim: A paper or electronic billing. This billing must include full details of the service received, including name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis and any other information which a plan may request in connection with services rendered.

Claim Payment: The benefit payment calculated by a plan, after submission of a claim, in accordance with the benefits described in this handbook and the annual Benefit Choice Options booklet.

Coinsurance: The percentage of the charges for eligible services for which the plan participant is responsible after any applicable deductible has been met.

College Choice Health Plan (CCHP) Hospital: A hospital or facility with which the College Choice Health Plan plan has negotiated favorable rates.

Coordination of Benefits: A method of integrating benefits payable under more than one group insurance plan.

Copayment: A specific dollar amount the plan participant is required to pay for certain services covered by a plan.

Covered Services: Services that are eligible for benefits under a plan.

Creditable Coverage: The amount of time a plan participant had continuous coverage under a previous health plan.

Custodial Care: Room and board or other institutional or nursing services which are provided for a patient due to age or mental or physical condition mainly to aid in daily living; or, medical services which are given merely as care to maintain present state of health and which cannot be expected to improve a medical condition.

Deductible: The amount of eligible charges plan participants must pay before insurance payments begin.

Department: The Department of Central Management Services, also referred to as DCMS.

Glossary (cont.)

Dependent Beneficiary/Dependent: A benefit recipient's spouse, civil union partner, child, parent or other person as defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Diagnostic Service: Tests performed to diagnose a condition due to symptoms or to determine the progress of an illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms (ECG), electroencephalograms (EEG), radioisotope tests and electromyograms.

Eligible Charges: Charges for covered services and supplies which are medically necessary and based on usual and customary charges as determined by a plan administrator.

Emergency Services: Services provided to alleviate severe pain or for immediate diagnosis and/or treatment of conditions or injuries such that in the opinion of the prudent layperson might result in permanent disability or death if not treated immediately.

Exclusions and Limitations: Services not covered under the College Insurance Program, or services that are provided only with certain qualifications, conditions or limits.

Experimental: Medical services or supplies in which new treatments or products are tested for safety and effect on humans.

Explanation of Benefits (EOB): A statement from a plan administrator explaining benefit determination for services rendered.

Final Internal Determination: The final benefit determination made by a plan administrator after a plan participant has exhausted all appeals available through the plan administrator's formal internal appeals process.

Fiscal Year (FY): Begins on July 1 and ends on June 30.

Formulary (Prescription Drugs): A list of drugs and ancillary supplies approved by the prescription drug plan administrator for inclusion in the prescription drug plan. The formulary list is subject to change.

Fully Insured: All claims and costs are paid by the insurance company.

Generic Drug: Therapeutic equivalent of a brand name drug and must be approved by the U.S. Food and Drug Administration for safety and effectiveness.

Hospice: A program of palliative and supportive services for terminally ill patients that must be approved by a plan administrator as meeting standards including any legal licensing requirements.

Hospital: A legally constituted and licensed institution having on the premises organized facilities (including organized diagnostic and surgical facilities) for the care and treatment of sick and injured persons by or under the supervision of a staff of physicians and registered nurses on duty or on call at all times.

Identification Card: Document identifying eligibility for benefits under a plan.

Independent External Review: An external review, conducted by an independent third party of a plan administrator's adverse claim determination or final internal determination.

Injury: Damage inflicted to the body by external force.

Inpatient Services: A hospital stay of 24 or more hours.

Intensive Outpatient Program (Behavioral Health Services): Services offered to address treatment of mental health or substance abuse and could include individual, group or family psychotherapy and adjunctive services such as medical monitoring.

Investigational: Procedures, drugs, devices, services and/or supplies which (a) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (b) are awaiting endorsement by the appropriate National Medical Specialty College or Federal Government agency for general use by the medical community at the time they are rendered to a covered person, and (c) with respect to drugs, combination of drugs and/or devices, which have not received final approval by the Food and Drug Administration at the time used or administered to the covered person.

Glossary (cont.)

Itemized Bill: A form submitted for claim purposes; must have the name of the patient, description, diagnosis, date and cost of services provided.

Medical Documentation: Additional medical information required to substantiate the necessity of procedures performed. This could include daily nursing and doctor notes, additional x-rays, treatment plans, operative reports, etc.

Medicare: A federally operated insurance program providing benefits for eligible persons.

Medicare Summary Notice (MSN): A quarterly statement from Medicare explaining benefit determination for services rendered.

Member: Benefit recipient or COBRA participant.

Nonpreferred Brand Drug: Prescription drugs available at the highest copayment. Many high cost specialty drugs fall under the nonpreferred drug category.

Out-of-Pocket Maximum: The maximum dollar amount paid out of pocket for covered expenses in any given plan year. After the out-of-pocket maximum has been met the plan begins paying at the 100% of allowable charges for eligible covered expenses.

Outpatient Services (Behavioral Health Services): Care rendered for the treatment of mental health or substance abuse when not confined to an inpatient hospital setting.

Outpatient Services (Medical/Surgical): Services provided in a hospital emergency room or outpatient clinic, at an ambulatory surgical center or in a doctor's office.

Partial Hospitalization (Behavioral Health Services): Services offered to address treatment of mental health or substance abuse and could include individual, group or family psychotherapy. Services are medically supervised and essentially the same intensity as would be provided in a hospital setting except that the patient is in the program less than 24 hours per day.

Physician/Doctor: A person licensed to practice under the Illinois Medical Practice Act or under similar laws of Illinois or other states or countries; a Christian Science Practitioner listed in the Christian Science Journal at the time the medical services are provided.

Plan: A specifically designed program of benefits.

Plan Administrator: An organization, company or other entity contracted to review and approve benefit payments, pay claims, and perform other duties related to the administration of a specific plan.

Plan Participant: An eligible person enrolled and participating in the College Insurance Program.

Plan Year: July 1 through the following June 30.

Preexisting Condition: Any disease, condition, (excluding maternity) or injury for which the individual was diagnosed, received treatment/services, or took prescribed drugs during the three months immediately preceding the effective date of coverage.

Preferred Brand Drug: A list of drugs, biologicals and devices approved by the pharmacy benefit manager for inclusion in the prescription drug plan. These drugs are proven to be both clinically and cost effective. The preferred brand drug list is subject to change.

Prescription Drugs: Medications which are lawfully obtained with a prescription from a physician/doctor or dentist.

Pretreatment Estimate (Dental): A provider's statement, including diagnostic x-rays and laboratory reports describing planned treatment and expected charges which is reviewed by the dental plan administrator for verification of eligible benefits.

Preventive Service: Routine services which do not require a diagnosis or treatment of an illness or injury.

Primary Care Physician/Primary Care Provider (PCP): The physician or other medical provider a plan participant selects under a managed care plan to manage all healthcare needs.

Glossary (cont.)

Professional Services: Eligible services provided by a licensed medical professional, including but not limited to a physician, radiologist, anesthesiologist, surgeon, physical therapist, etc.

Program: The College Insurance Program as defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.).

Provider: Any organization or individual which provides services or supplies to plan participants. This may include such entities as hospitals, pharmacies, physicians, laboratories or home health companies.

Qualified Beneficiary: A qualified beneficiary is an individual (including member, spouse, civil union partner or child) who loses employer-provided group health coverage and is entitled to elect COBRA coverage. The individual must have been covered by the plan on the day before the qualifying event occurred and enrolled in COBRA effective the first day of eligibility or be a newborn or newly adopted child of the covered member.

Schedule of Benefits: A listing of specific services covered by the College Choice Dental Plan and the vision plan.

Second Opinion: An opinion rendered by a second physician prior to the performance of certain nonemergency, elective surgical procedures or medical treatments.

Self Insured: All claims and costs are paid by the College Insurance Program.

Skilled Nursing Service: Noncustodial professional services provided by a registered nurse (RN) or licensed practical nurse (LPN) which require the technical skills and professional training of such a licensed professional acting within the scope of their licensure.

Spouse: A person who is legally married to the benefit recipient as defined under Illinois law and pursuant to the Internal Revenue Service Code.

State Employees Group Insurance Act: The statutory authority for benefits offered by the Department (5 ILCS 375/1 et seq.).

Survivor: Spouse, civil union partner, dependent child(ren) or dependent parent(s) of a deceased member as determined by the State University Retirement System.

Surgery: The performance of any medically recognized, noninvestigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by a plan.

Urgent Care Claim: Any claim for medical care or treatment with respect to the application of the time periods for making nonurgent care determinations could:
1) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2) in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Index

Index (cont.)

*The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits, program requirements and contributions described in this Handbook. Changes will be communicated through addenda as needed and the annual Benefit Choice Options Booklet. If there is a discrepancy between this Handbook or any other Department publications, and state or federal law, the law will control.**

* *Note: The original version of the October 1, 2011, Benefits Handbook inadvertently omitted the above reservation of rights due to an oversight during the graphic design process. This omission in no way represents and should not be construed as a lapse of, suspension of or exception to this reservation of rights. The State of Illinois has continuously maintained this reservation of rights since at least 1994 through the present. The State of Illinois continues to apply this reservation of rights on an ongoing basis, effective until such time as the State expressly waives or terminates this reservation of rights in writing.*

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